Maternal and Child Health Services
Title V Block Grant

State Narrative for New York

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications will be kept on file in the office of the Title V Director, New York State Department of Health, Division of Family Health, Corning Tower Room 890, Empire State Plaza, Albany NY 12237-0567. In addition, assurances and certifications are reprinted in hardcopy and web-based versions of the block grant application. Hardcopies are available at the above address. The grant application appears on the New York State Department of Health Website at: www.health.state.ny.us.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

New York State is substantially invested in obtaining public input into the state's MCH Program. Because of the diverse methods that contribute to the assessment of needs and capacity, NYSDOH can be confident that the needs assessment and resulting program development reflect the needs of communities in our state. Major avenues for stakeholder input related specifically to the five year needs assessment process for the Title V Block Grant Application include the following:

- The Department's Prevention Agenda development process

In April, 2008, Commissioner Daines launched the Prevention Agenda for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The Prevention agenda was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the priority areas, the Prevention Agenda focuses on eliminating the profound health disparities that impact racial and ethnic minorities.

- A survey of stakeholders related to MCH needs and priorities The Department's Needs Assessment leadership team developed a survey for key stakeholders to obtain their input related to the needs and priorities for the MCH populations in New York State. The survey included background information related to the MCH Block Grant, as well as specific information regarding current national outcome measures, performance measures and current state priorities. The survey was sent to over 183 MCH stakeholders, stakeholders in the Department and other state agencies, as well as a substantial number of external partners, including perinatal consortia and regional perinatal centers, advocacy organizations, community based agencies servicing the MCH population, professional organizations and consumers.
- Regional forums for youth/young adults with special health care needs and families of children with special health care needs were conducted in February and March 2010 by the

CSHCN Program to gather consumer input about the system of care for children and youth/young adults. The forums were facilitated to elicit information about the core Maternal and Child Health Bureau performance measures

• A survey of families of children with special health care needs and youth representatives was developed to elicit feedback for the Maternal Child Health Block Grant application item 13, "Characteristics Documenting Family Participation in the CSHCN Program".

• Focus groups with adolescents and their families were conducted to inform the DOH about how young people get information about sexual health, where they go for sexual health care services, their experiences in accessing services, and their unmet needs. The Adolescent Sexual Health Focus Group study was conducted by the DOH-funded adolescence Center of Excellence (COE) at Cornell University (and their partners at University of Rochester School of Medicine, NYS Center for School Safety and New York City Cornell Cooperative Extension).

• MCHBG Advisory Council discussions related to MCH needs and priorities, development of the Maternal and Child Health Block Grant needs assessment and application was an agenda item for several Council meetings. In addition, a special session of the Council was convened with an agenda exclusively focused upon a review of needs assessment activities and results and development of state priorities.

• Incorporation of local level stakeholder input to inform the state level assessment, including structured listening sessions with:

- the MCH committee of the New York State County Health Association which includes seventeen county members

- local perinatal networks which represent consortia of health and human service providers who address MCH issues at the local level. These networks also co-chair regional perinatal forums which are also co-chaired by regional perinatal centers. These forums provide a comprehensive picture of MCH needs, incorporating both the community and hospital perspectives.

- the New York City Department of Health and Mental Health MCH Bureau.

? In addition to these efforts to obtain input during the development of the application, a draft copy of the application was made available to key stakeholders, including the perinatal networks, the MCHBG Advisory Council, the MCH Committee of NYSACHO to provide any additional input for consideration prior to submission.

? The application was also posted on the Department's website to obtain further information regarding development and implementation of the needs assessment.

? A summary of the needs assessment process, including the results of the survey and proposed changes to state priorities and performance measures, was presented on June 17th at the New York Perinatal Association Conference with an opportunity to comment.

Each of these activities to obtain public input into the block grant is described in more detail in the Needs Assessment Section.

In addition, to the specific efforts described above to obtain public input related to assessment of need and development of state priorities, the Department has a significant number of regular mechanisms to obtain public input related to needs assessment, priority identification and resource allocation and program planning, development, implementation and evaluation. This includes obtaining ongoing input from families of CSHCN. These mechanisms are also described in more detail in the Needs Assessment Section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Department's goal in the need assessment process is to comprehensively review the needs of the MCH populations; to examine existing program priorities and realign those priorities to address new identified needs to the extent that resource permit; and, to clearly assess performance related to program priorities to ensure MCH programming results in real improvement in the health and well being of the MCH populations in New York State. The needs assessment process was developed based upon three main components: stakeholder input from a variety of sources; analysis of extensive MCH data; and, information obtained from needs assessment cycles for specific MCH programs. This information was synthesized in making decisions regarding state priorities.

Major avenues for stakeholder input included the following: the Department's Prevention Agenda development process; a survey of stakeholders related to MCH needs and priorities; regional forums for youth/young adults with special health care needs and families of children with special health care needs; a survey of families of children with special health care needs and youth representatives; focus groups with adolescents and their families; MCHBG Advisory Council discussions related to MCH needs and priorities; and, local level stakeholder input, including the MCH committee of NYSACHO, local perinatal networks and the NYCDOHMH.

Determining what should be identified as a state priority and how those priorities should be ranked was based upon a number of factors including degree of stakeholder input identifying an issue as a priority; current capacity to meet identified needs, whether the need related to a health disparity / disparities, as well as other factors. The following are revised State Priorities for the 2011 through 2016 MCHBG grant cycle:

1. State Priority (revised): To improve access to early, adequate and high quality prenatal care, with a specific focus on eliminating health disparities
2. State Priority (revised): To improve access to comprehensive, high quality primary and preventive health care for children and adolescents, consistent with the medical home model, including children with special health care needs
3. State priority (current): To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality
4. State Priority (revised): To prevent and reduce the incidence of overweight and obesity for infants, children and adolescents, with a focus upon reducing health disparities
5. State Priority (revised): To reduce unintended pregnancies in adults and adolescents and improve adolescent sexual health and development, with a focus upon reducing health disparities
6. State Priority (current): To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women
7. State Priority: (current) To improve oral health, particularly for pregnant women, mothers and children, and among those with low income
8. State Priority (new): To eliminate childhood lead poisoning
9. State Priority: (current) To improve diagnosis and appropriate treatment of asthma in the maternal and child health population.
10. State Priority (new): To increase the percentage of infants who are breastfed for at least six months.

In addition to the ten State priority measures, two outcome measures have been selected for this period:

1. State Outcome Measure: Maternal mortality rate per 100,000 births
2. State Outcome Measure: The percentage of elective deliveries, both cesarean sections and inductions, performed without appropriate indication between 36 and 38 6/7 weeks gestation.

New York State has made progress in reducing unintended and adolescent pregnancy, smoking in pregnancy, perinatal HIV transmission, delivery of very low birth weight babies in higher level hospitals, infant and neonatal mortality and breastfeeding rates over the past ten years. The statewide rates of early prenatal care and adequacy of prenatal care and alcohol use in pregnancy and post neonatal death have been stagnant. Rates of c-section delivery, preterm birth, low birth weight and maternal mortality have increased. In addition, children's health measures related to lead, immunization, oral health, asthma and obesity and tobacco use have generally improved. Chlamydia morbidity has continued to increase since reporting began in 2000. High rates of newborn screening and follow up continue, including significant increases in newborn hearing screening and children identified with autism. Despite the significant positive changes in outcomes, New York State is below Healthy People 2010 objectives for several measures, and, health disparities continue to be significant. The percent of children, including CSHCN, who have insurance coverage and who have a medical home have improved, though some other access and quality measures for primary and specialty care for CSHCN have been relatively stagnant.

Since the last MCHBG grant cycle, there have been significant changes in State capacity related to priorities. Reform in the State's public health insurance programs has been extensive with positive impacts upon MCH populations. In addition, new state funding became available to support a variety of initiatives, including support for: family planning and school based health clinics; emergency contraception; access to the HPV vaccine; home visiting; adolescent pregnancy prevention; perinatal regionalization; and, obesity, as well as others. The Department has also received federal grants and ARRA funding that has supported a variety of critical MCH initiatives, including newborn hearing screening and autism, breast feeding, immunization and obesity. Significant investments in MCH infrastructure have been made in improving quality analysis, integration and access to MCH data, as well developing initiatives to improve quality of MCH programs and services.

III. State Overview

A. Overview

The mission of the NYSDOH is to ensure that high quality appropriate health services are available to all NYS residents. Department functions and responsibilities include:

•Promoting and supervising public health activities throughout the State;
•Ensuring high quality medical care in a sound and cost effective manner for all residents;
•Reducing infectious diseases such as food and waterborne illnesses, hepatitis, HIV, meningitis, sexually transmitted infections, tuberculosis, vaccine preventable diseases and chronic disabling illnesses such as heart disease, cancer, stroke and respiratory diseases; and,
•Directing a variety of emergency preparedness initiatives in response to statewide and local epidemic outbreaks.

In a state as large and diverse as New York, achieving the mission is a daunting task. This task has now been complicated by the fact that New York is faced with the great economic and fiscal challenges. Wall Street, a pillar of New York's economy, has suffered a series of unprecedented shocks. The financial services sector, which accounts for twenty percent of state tax revenues, has been negatively impacted. Moreover, New York's broader economy is grappling with a deep recession that promises to be one of the worst in decades, and is expected to cost tens of thousands of New Yorkers their livelihoods. Both financial and human resources are limited to accomplish the Department's core mission. Yet, despite these obstacles, the Department is committed to ensuring New York meets the needs of its most vulnerable maternal and child health population.

Maximizing resources and cultivating collaborative relationships is essential to moving beyond this crisis. The Department works with the State's health care community to ensure appropriate readiness and response to potential public health threats. The Department is also the principal State agency that interacts with the Federal and local governments, health care providers and program participants for the State's Medicaid program.

Under the direction of the Commissioner, Dr. Richard Daines, who is appointed by the Governor, the Department meets its responsibilities through the Office of Health Insurance Programs (OHIP), the Office of Long Term Care, the centers located in the Office of Public Health, and the Office of Health Systems Management. In 2007, the Department established OHIP which consolidated operations of the State's public health insurance programs under the direction of the State Medicaid Director. OHIP is responsible for developing and implementing strategies to improve access to health insurance coverage for the uninsured and providing for an integrated approach to oversight and administration of the Medicaid program to strengthen coordination within the Department and among State agencies. The establishment of OHIP marked the adoption of a new mission for Medicaid, namely to expand coverage and access; to buy value with New York's heath care dollars; and, to advance system wide reform. The Office of Health Insurance Programs is responsible for Medicaid, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The Office of Long Term Care oversees the integration of planning and program development for services related to long term care. The Office of Public Health and the Office of Health Systems Management are responsible for providing policy and management direction to the Department's system of regional offices. Department staff located in regional offices conduct health facility surveillance, monitor public health, provide direct services and oversee county health department activities. In addition, the Department also contracts with organizations, such as the Island Peer Review Organization (IPRO), to conduct monitoring and surveillance activities for programs such as the Early Intervention Program. The Department is also responsible for five health care facilities that are engaged in patient care: the Helen Hayes Hospital in West Haverstraw, which offers specialty rehabilitation services, and four nursing homes for the care of veterans and their dependents in Oxford, New York City, Batavia and Montrose.

The Office of Public Health (OPH) was established in 2007 to strengthen coordination among the Department's public health programs and to ensure public health input into all the Department's programs. OPH is made up of the Department's four principal public health centers:
•AIDS Institute;
•Center for Community Health;
•Center for Environmental Health; and,
•Wadsworth Center.

In addition, the Office of Public Health Practice (formerly the Office of Local Health Services in the Center for Community Health), the Health Emergency Preparedness Program and the CDC Senior Management Official in New York report to OPH.
The purposes of the OPH are to:
•continue and increase coordination and integration across the department's public health centers and programs;
•assure that public health is fully represented at the departmental level including full incorporation of public health principles into the redesign of the health care system and health insurance programs;
•keep New York active as an innovator in the emerging areas on the cutting edge of public health practice such as maternal and child health; chronic disease prevention; nutrition; environmental health; laboratory science; prevention and control of infectious diseases such as HIV, hepatitis C and others; genomics and informatics;
•coordinate public health activities with the Centers for Disease Control and Prevention, other federal agencies, other state health departments, and local health departments in New York;
•convene partners in the community, academia and the health care system to further public health goals; and,
•rebuild and strengthen the state and local public health infrastructure.

The Center for Community Health (CCH) works with communities to promote good public health for all New Yorkers. Whether it's developing programs to improve perinatal health, encourage people to exercise and eat healthier, or helping communities reduce the incidence of disease, or helping young people build their self-esteem so they can become tomorrow's leaders, the focus is always on community action to help make the difference.

A priority of the CCH is to address the root causes of diseases, not just the diseases themselves, in order to make a longer term impact. Aiming programs at the problems of obesity, lack of exercise, poor diet and smoking, helps reduce illness and death from a variety of diseases including heart disease, cancer, diabetes mellitus and stroke--the nation's leading killers. Making sure children's homes are free of lead and that children are screened early in life for lead poisoning helps prevent a lifetime of underachievement and behavioral problems.

The majority of deaths in New York State are not caused by inadequate access to health care (10%) but by behavioral (50%), environmental (20%), and genetic (20%) factors that can be addressed by public health actions. According to a report on Public Health in America produced by the U.S. Department of Health and Human Services in 1994, public health provides ten essential services:
•Monitor health status to identify community health problems;
•Diagnose and investigate health problems and health hazards in the community;
•Inform, educate, and empower people about health issues;
•Mobilize community partnerships to identify and solve health problems;
•Develop policies and plans that support individual and community health efforts;
•Enforce laws and regulations that protect health and ensure safety;
•Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
•Assure a competent public health and personal health care workforce;
•Evaluate effectiveness, accessibility, and quality of personal and population-based health

services; and,
•Research for new insights and innovative solutions to health problems.

The CCH's responsibilities are broad and far-reaching, touching every aspect of public health in NYS. CCH identifies and assists local agencies with disease outbreaks, makes nutritious foods available to pregnant women, infants and children and tracks cancer incidence across the state. The center conducts public health surveillance to help identify and respond to emerging health threats; to plan, implement and monitor public health programs that respond to these threats; and to show New Yorkers how to minimize health risks. CCH staff helps local health agencies and community organizations fight the root causes of poor birth outcomes, killer diseases such cancer, heart disease and diabetes, help protect children from lead poisoning, and work to prevent people from starting to use tobacco and they help those already hooked to quit. Through surveillance, education, prevention and treatment they fight tuberculosis, adolescent pregnancy, sexually transmitted diseases, injuries, abuse, hunger, diseases carried by animals and insects, osteoporosis, dementias and the other public health threats known and still to be discovered. CCH staff work closely with the staff of other centers--Center for Environmental Health, Wadsworth Center, AIDS Institute--that make up the New York State Health Department's Office of Public Health (OPH). The OPH umbrella helps strengthen coordination among public health programs and ensures public health input into all the department's programs.
CCH consists of four Divisions, including:
•The Division of Family Health that promotes the health of families by assessing needs, promoting healthy behaviors and providing services to support families.

•The Division of Chronic Disease and Injury Prevention that addresses specific risk factors associated with the leading causes of death, disability and chronic disease among New Yorkers.
•The Division of Nutrition that manages programs designed to improve the nutritional status of the residents of New York State. Improving the diet of the public is a key factor in improving public health among those most at risk for serious illness.
•The Division of Epidemiology whose mission is to use sound scientific practices and principles to protect the health of all New Yorkers through disease surveillance, expert technical assistance, collaborations with local health departments and health care professionals, and by sharing expertise, epidemiologic information, and knowledge the division confronts a variety of new and emerging communicable diseases found in the state.

CCH also includes an Office of Minority Health, which assists all Center programs in better serving the needs of minority populations, an Internet Development and Communications unit, which facilitates development of web-based materials, an Office of Information Technology and Project Management, and a Resource Management Unit. This arrangement of services within the Center helps to ensure proper oversight and assistance of all program functions within the Center.

New York's Title V program is located in the Division of Family Health in the Center for Community Health. The Division's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents considering sexual activity, children with disabilities, rape victims and children with asthma, lead poisoning or lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. The division provides access to primary medical and dental care and preventive health services for migrant farmworkers and Native Americans living in reservation communities. The Division consists of the:
•Bureau of Maternal and Child Health;
•Bureau of Early Intervention;
•Bureau of Dental Health;
•Division Fiscal Unit;
•Office of the Medical Director.

The DFH works very closely with the other Divisions within CCH, particularly the Division of

Nutrition (DON) and the Division of Chronic Disease Prevention and Adult Health (DCDPAH), as well as with the major organizational segments of the Department whose work complements that of the Division, in particular the Office of Health Systems Management (OHSM) and the Office of Health Insurance Programs (OHIP). DON, which includes the WIC program and various other nutrition and fitness programs, works closely with the DFH in implementing both prenatal programs and children's programs to ensure that the nutritional needs of at risk pregnant and nursing women as well as infants and children are being met. DCDPAH works closely with the DFH on programs such as the family planning program, which collects extensive annual data on Chlamydia testing for reproductive age women in NYS, with the cancer screening program in referral of women for screening and treatment for breast and cervical cancer and the provision of HPV vaccine. The DFH, DON and DCDPAH are also collaborating on a major effort to promote exclusive breastfeeding in New York State. Ongoing communication and collaboration are essential to ensure messaging is consistent in areas such as preconception health, screening for intimate partner violence and substance use and abuse, among other topics of importance to Title V.

OHSM oversees all hospitals and licensed clinics as well as related services in NYS. These facilities, licensed under Article 28 of the Public Health Law to provide health care services, are frequently targeted by the Division's programs in RFPs as eligible awardees for contracts. Since the licensing and monitoring process carried out on an ongoing basis ensures that facilities obtain approval for provision of specific services, these facilities have a demonstrable range of services and quality of care level appropriate for many of the services and programs provided by the DFH. Further, the BMCH, in particular, within DFH, collaborates closely with OHSM in designation of hospitals for level of perinatal care, and in fact drafted the revisions of hospital regulations on which these designations are based, as well as certifying hospitals as Sexual Assault Centers of Excellence (SAFE Centers). BMCH and DFH are consulted by OHSM whenever hospital or clinic closures are threatened, to ensure that sufficient service providers are available to meet the obstetric and perinatal needs within the region.

There has been a long and very close partnership between the state's Medicaid programs and the state's maternal and child health programs in New York State. The DFH worked closely with OHIP over the past couple years on major initiatives of significance to the MCH population including the transition of the Prenatal Care Assistance Program to the Medicaid Prenatal Care Program, revising prenatal care program policies and standards to conform with current standards of professional practice, streamlining enrollment of pregnant women from Fee for Service Medicaid into Managed Care, improving the coordination of home visiting services, including the development of a Risk Summary form to better ensure providers are working with Managed Care Plans to address identification and referral of pregnant women at risk for poor birth outcomes, development and implementation of the new Ambulatory Patient Group reimbursement to ensure providers were adequately reimbursed for comprehensive services, and efforts such as submission of the 1115 Medicaid Waiver to ensure New York can continue to provide comprehensive reproductive health services to eligible populations of the state. DFH is working closely with OHIP on an ongoing basis to ensure that guidelines for high quality care are in place, in addition to helping inform providers of changes, streamline application processes, and generally provide a systems level approach to implementation.

A further characteristic of the state's Title V program is maintenance of local level contacts through the network of regional offices around the state. These offices all have family health directors, who regularly communicate with the Title V Director via meetings or telephone contacts, as required, of local level issues that might potentially influence services or health care status of Title V populations in any area of NYS.

Title V's position within the OPH promotes collaborative efforts with programs and services aimed at the maternal and child health population and promotes maximizing resources to improve health outcomes.

Title V priorities align with the Department's overall priorities. At a hearing held by the New York State Division of Budget in February, 2010, Dr. Richard Daines, the Department's Health Commissioner, outlines the Department's priorities for the coming years. Dr. Daines stressed that, at a time when many New Yorkers are facing difficult financial challenges and the State must close a growing budget deficit estimated at $8.2 billion dollars for the next fiscal year, there are several themes that run through all of the Department's budget proposals for the new fiscal year including:
•preserving services that support the Department's core mission of protecting and improving the public's health;
•achieving reforms that increase efficiency while maintaining quality;
•accountability and transparency;
•elimination of duplication of services;
•consolidation, streamlining and simplification;
•flexibility to target resources where they are needed most; and,
•use of innovation to reduce the State's greatest public health threats while at the same time helping to reduce the deficit.

Major priority areas of the Department closely align with the priorities of New York's Title V program including:
•Obesity Prevention - Overweight and obesity are now challenging smoking for the top public health threat in New York State. Currently, about 60 percent of adults and 35 percent of children and adolescents in New York State are obese or overweight. The increase in overweight and obesity is dramatically increasing New Yorkers' risk for many chronic and debilitating conditions -- including heart disease, diabetes, hypertension, and some cancers. New York's obesity agenda includes the promotion of exclusive breastfeeding, initiatives to increase exercise among children and improve nutrition, including a calorie posting requirement, a ban on the use of trans fats in certain restaurants and food service establishments, a ban on the sale of high-fat, high-sugar junk foods in schools, and a proposed $10 million dollar revolving loan fund to increase access to healthy foods in underserved communities.
•Tobacco prevention and control - Tobacco use continues to be New York's number one cause of preventable disease and death. Health care costs related to treating smoking-caused diseases total approximately $8 billion annually for New York alone. Between 2007 and 2008, the adult smoking rate in New York State declined from 18.9 percent to 16.8 percent, resulting in 310,000 fewer smokers in only one year.
•Lead poisoning -- New York has made a commitment to end childhood lead poisoning in New York State. Childhood lead poisoning has decreased by 17 percent in upstate New York since 2005. The Childhood Lead Poisoning Primary Prevention Program is a priority of the Department to keep New York's children safe from this public health threat.
•HIV/AIDS and Sexually Transmitted Diseases -- The Department remains committed to addressing the AIDS/HIV epidemic and addressing sexually transmitted diseases.
•Targeting primary and preventive public health strategies that will decrease obesity rates, increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visiting, high-quality mammograms and public health education.
•Early Intervention Program -- The Department continues to work on reforms to the program including a variety of administrative actions that would require preferred assessment tools, modify speech eligibility standards, and revise reimbursement rates. In addition, the budget proposes legislative actions that require providers to bill Medicaid, maximize commercial insurance reimbursement, and establish an early intervention parent fee.
•Ensuring there are health care professionals available to meet the primary and preventive health care needs in New York's underserved areas of the state;
•Ensuring that the Graduate Medical Education (GME) system provides the state with the value desired for the funds invested;
•No longer using Medicaid to cross-subsidize commercial insurers, nor supporting deep discounts for hospital services their members use.
•Paying fair reimbursements that reflect the true costs of providing high-quality care through a

workforce whose needs are met fairly, redirecting Medicaid dollars to those facilities that serve the bulk of the Medicaid patients.
•Purchasing health care in the appropriate setting, using the highest standards at the best price, and starting with the patients that have multiple medical needs. With better coordination of care, patients with medically-complicated conditions will get better care, their conditions will be better managed, and the cost of their total care will be reduced.
•Expanding the managed long-term care programs which have been successful in coordinating and managing long-term care needs.
•Driving the implementation of health information technology, which is essential to improving health care quality, reducing bureaucratic barriers and saving health care dollars.
•Increasing efforts to root out Medicaid fraud, which wastes precious resources and reduces our ability to care for those in need.

The Governor's proposed Budget for 2010 continues the historic health care reforms achieved over the last two years. The Department's efforts focus on achieving greater efficiency without creating barriers to enrollment for those eligible for Medicaid services. New York continues to rank first in the nation in Medicaid spending per capita -- twice the national average. In New York, Medicaid is the largest single payer of health care, so through Medicaid reform, the Department will have an opportunity to leverage changes in the health care system. These reforms fully support the mission of New York's Title V program in ensuring comprehensive primary and preventive health and support services to the maternal and child health population, including children with special health care needs.

New York also leads the nation in Medicaid inpatient hospital spending. The State ranks 4th on per enrollee inpatient hospital spending and spends almost twice the national average. To better serve patients in the right setting at the right price, New York has invested more than $600 million in outpatient care in the last two years. The investments include investments in hospital programs, including outpatient clinics, ambulatory surgery, and emergency room; physicians' fees; primary care; freestanding programs; and, mental hygiene enhancements.

Another critical component of New York's historic health care reform of the last two years has been the updating of the decade-old hospital reimbursement system and addressing the issue of potentially preventable hospital readmissions. Potentially preventable readmissions occur because the patient is discharged too soon or too sick or because of a lack of follow-up care in the community following the discharge. The 2010-11 Executive Budget proposes to begin reducing funding for preventable admissions and in 2012 begins to reinvest a portion of the savings in rewarding hospitals that reduce readmissions and in post discharge linkages. The budget also funds an additional 100 slots for Doctors Across New York -- 50 for physician loan repayment and 50 for physician practice support -- to improve access in medically underserved areas of the state.

The Department continues its efforts to make it easier for eligible individuals to access public health insurance programs. Since 2008, the Department has permitted self-attestation of income and residency at renewal for non-SSI related Medicaid beneficiaries and Family Health Plus members. The 2010-11 proposed budget permits Medicaid enrollees receiving community-based long-term care to attest to their income and residency at renewal. The budget also proposes to allow the Department to pursue a federal option called Express Lane eligibility for children in Medicaid and Child Health Plus, that will allow children to transfer between Medicaid and Child Health Plus more easily, and it will allow for easier enrollment of children already in receipt of food stamps.

Plans are also underway for the implementation of the Statewide Enrollment Center that will consolidate the Medicaid, Family Health Plus, and Child Health Plus toll-free numbers to provide one-stop shopping for persons already enrolled in public health insurance and for those seeking information about applying, and it will augment the local social services districts by processing telephone and mail-in renewals.

The Health Care Reform Act (HCRA) at the federal level may significantly impact New York's public health programs and maternal and child health services, and support New York's efforts in this arena. Although the Department awaits specific guidance around some of these areas, the federal Patient Protection and Affordable Care Act will assist the Department to achieve improved maternal and child health outcomes if the Department has the ability to obtain funding and support. The Department has already been awarded a small Community Transformation Grant from the Centers for Disease Control and Prevention (CDC) through the Communities Putting Prevention to Work (CPPW) initiative. The Title V staff is collaborating with the Division of Chronic Disease to implement this grant that will help support the Department's initiative to increase exclusive breastfeeding rates in New York State. The Department is also awaiting guidance on the Oral Healthcare Prevention and Education component that will establish a 5-year national public health education campaign focused on oral healthcare prevention and education. Several Department contractors in New York are applying for the Personal Responsibility Education that will support programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. This funding that will augment adolescent health services in the state. The OHIP has also obtained state plan approval to provide Medicaid funding support to two of these programs in Monroe County and New York City as targeted case management programs. The Department will evaluate whether to apply for Abstinence Education funds if the guidance allows comprehensive sex education and evidence-based practices. The Support, Education, and Research for Postpartum Depression component will amend Title V to provide new grants to states to provide services to individuals with, or at risk, of postpartum depression and their families. The Department is well positioned to use this funding to continue work on promoting identification, referrals and services for perinatal depression.

The Maternal, Infant, and Early Childhood Home Visiting Programs component that creates a new section in Title V to provide funding to States to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s) if of tremendous interest in support of the New York's evolving work on home visiting. Title V staff are currently planning a comprehensive needs assessment process on home visiting in New York in collaboration with the several State agencies pending final guidance from the federal government.

The new federal law also contains measures that will enhance New York's already rich public health insurance system. The following are major highlights of those provisions impacting New York State.

•Medicaid Expansion. Creates a new mandatory Medicaid eligibility category for most adults and children with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. States are required to adopt a "modified adjusted gross income" (MAGI) test to further streamline eligibility determinations. The OHIP will be working with CMS to define the MAGI to ensure greater access for New York's uninsured or underinsured population. Eligibility for most non-disabled adults under age 65 will be based on this MAGI.

•New York State is already in compliance with the requirement that there be no resource test for most populations, including pregnant women, most families, children and single adults. That provision is required by the HCRA starting in 2014.

•State Health Insurance Exchange. The bill sets up a state health insurance exchange to offer basic health programs. States would have option to offer a community health insurance plan, similar to state plan and be able to offer a waiver to plans showing innovation around care management, care coordination and incentives for using preventive services. HCRA requires improved coordination of seamless enrollment for all programs, requires a single form, with on-line, in person, mail and telephone application options for the programs.

•Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019. Low income children will continue to be covered in New York up to 400% of the FPL either through Child Health Plus, Medicaid or the Exchange.

There are also provisions that will bolster New York's health care system, especially for

underserved areas of the state, including:
•Community Health Centers. Creates a Community Health Center (CHC) Fund that provides mandatory funding for the Community Health Center program, the National Health Service Corps, and construction and renovation of community health centers. The Department is ensuring that CHCs are positioned to apply for grant funding to serve New York's populations whenever feasible.
•Increasing Primary Care and Public Health Workforce. Includes numerous provisions intended to increase the primary care and public health workforce by including amended and expanded health workforce programs authorized under Title VII (health professions) and Title VIII (nursing) of the Public Health Service Act. A variety of incentives are included to support education and training of pediatric specialists, oral health providers, and nurses. Title V staff are working with the Office of Health Systems Management staff to identify workforce shortages and support community partners to address these shortages where possible.

Recognizing the complexity of Health Care Reform, the Governor created the Governor's Health Care Reform Cabinet to manage the implementation of federal health care reform in New York State. The Cabinet will advise and make recommendations to the Governor on all aspects of federal health care reform and strategic planning to guide the implementation of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. State agencies serving in the Cabinet include: the Department of Health, the Department of Insurance, the Division of the Budget, the Department of Civil Service, the Department of Taxation and Finance, the Department of Labor, the Office for Technology, the Office of Temporary and Disability Assistance, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office for the Aging, the Office of the Medicaid Inspector General, and the Office of Children and Family Services. The Deputy Secretary for Human Services, Technology and Operations, Deputy Secretary for Intergovernmental Affairs and Counsel to the Governor will also serve in the Cabinet. In addition, the Governor will name an external advisory group to assist and advise the Cabinet on reform provisions and ensure stakeholder and public engagement. The advisory group will include organizations representing health care providers, consumers, businesses, organized labor, local governments, and health plans and health insurers, as well as health policy experts. In this way, New York can be better assured that changes and improvements will be made to improve the health outcomes of all New Yorkers.

New York is also committed to ensuring all New Yorker's are insured and do not lose their insurance due to unnecessarily high premiums. To that end the Governor recently signed legislation requiring health insurers and HMOs to make an application to the State Insurance Department to implement premium increases. The Department would have the opportunity to review the rate applications, as well as the underlying calculations, to ensure that the rates are justified and not excessive, and may approve, modify or disapprove the rate application. The law would apply to all rate increases taking effect on or after October 1, 2010.

Through health care reform and investing in primary and preventive care, and strengthening New York's public insurance programs, as previously discussed, New York is striving to increase availability and accessibility of health care for historically underserved populations. In April, 2008, Commissioner Daines launched the Prevention Agenda for the Healthiest State, establishing 10 statewide public health priorities with an emphasis on prevention strategies. The Prevention agenda was a call to action, asking hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals related to two to three of the priorities. Across all the priority areas, the Prevention Agenda focuses on eliminating the profound health disparities that impact racial and ethnic minorities. The public health priorities include:
• Access to Quality Health Care
• Tobacco Use
• Healthy Mothers, Healthy Babies, Healthy Children
• Healthy Environment

• Physical Activity & Nutrition
• Community Preparedness
• Unintentional Injury
• Mental Health & Substance Abuse
• Chronic Disease
• Infectious Disease

Local Health Departments (LHDs) recorded their efforts in Community Health Assessments (CHA) and Municipal Public Health Service Plans (MHSP), which were submitted to the Department in July of 2009 as part of requirements for receipt of state funding through Article 6 of the NY Public Health Law. Hospitals submitted their Community Service Plans (CSP) in mid-September, 2009. With input from community members and stakeholders, two or three Prevention Agenda priorities were selected for community action and a plan was developed. By coordinating their needs assessment and program planning activities, all participants will be better able to meet the needs of their communities while avoiding duplicative efforts and achieving economies of scale. The goal is for local health departments and hospitals to develop shared visions of what must be addressed. The Department is providing technical assistance on accessing county-specific data, using evidence-based prevention approaches, and monitoring their impacts. Community-based efforts will be complemented by local and statewide policy initiatives to help achieve the prevention goals. Although Title V's major focus is Healthy Mothers, Healthy Babies, Healthy Children, all of the areas of focus impact health outcomes of the maternal and child health population.

As demonstrated in the Needs Assessment portion of this application, health disparities continue to exist in New York State, and addressing those factors leading to ethnic and racial disparities in health outcomes remains a Department priority. Health disparities in New York often occur along the lines of race, ethnicity, nativity, language ability, socioeconomic status, and geography, among other factors. The geographic distribution of New York State also complicates issues related to disparities as there is a great variation between rural and urban areas, providing a sharp contrast among residents and their access to health care services. Small community-based providers in underserved areas of the state often do not have the level of expertise and infrastructure to support comprehensible public health programs.

All efforts discussed previously are devoted to improving health outcomes for all New Yorkers, including ethnically and culturally diverse individuals. The major focus of the Department's efforts include partnerships at the state, local and community level. A 2009 report developed for the Department's Minority Health Council contained several strategies regarding eliminating disparities. The Title V program in New York State is working to operationalize these concepts to decrease the divide that exists among diverse groups in New York State. The report contained recommendations and promising strategies that New York could implement to potentially reduce disparities including:
•Leverage and expand core system and mission functions to assure an integrative approach for addressing health disparities
•Improve data collection, data systems, and mechanisms for monitoring and reporting disparities.
•Develop, implement and evaluate disparities interventions.
•Ensure leadership and stakeholder support for coordination of effort and institutionalize disparities-reduction work.

The report recognized New York's commitment to addressing disparities, but went on to state that stronger partnerships with local health departments to develop strategies to address disparities may impact the health disparity issue. To that end, the Commissioner has made the Prevention Agenda (discussed previously) a priority of state and local leaders. In April, 2010, local health departments and Department experts in specific topic areas (teen pregnancy prevention, prenatal care, obesity prevention) met to discuss local strategies to improve health outcomes and address disparities in selected health outcomes. These discussions focused on local public and private agencies that could partner to address specific issues, and evidence-based interventions and

promising practices to address health issues, including health disparities. Title V staff will continue to promote partnerships to improve the health outcomes of New York's diverse community.

The Department has access to a wealth of data and information to identify issues related to maternal and child health outcomes and disparities. Although resources have always been targeted at high risk populations of the state, a more concerted effort is being made to ensure resources are going to the highest need areas. For example, although New York's outcomes in many areas are improving, in areas such as adolescent pregnancy, disparities continue to exist due to increasing numbers of immigrant and hard to reach adolescents. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. The Department also provided statewide training to current and potential providers on evidence based programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system.

The Title V program also continues to prioritize resources and activities to address disparities in population-based screening programs such as lead poisoning prevention. The Department is taking a multi-pronged, comprehensive public health approach to prevent and eliminate childhood lead poisoning. This approach encompasses:
•Surveillance, data analysis and laboratory reporting;
•Education to families, health care providers, professionals and the public;
•Policy and program activities to advance primary prevention of lead poisoning to reduce lead hazards before children become poisoned;
•Policy and program activities to promote secondary prevention of lead poisoning, including blood lead testing of children and pregnant women;
•Assurance of timely, comprehensive medical and environmental management for children with lead poisoning; and,
•Response to emerging lead-related public health issues, such as lead poisoning among immigrant and refugee children and recalls of lead-contaminated consumer products.

Targeted efforts at disparate populations include collaborative efforts with the NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigration Affairs and the Department's Refugee Health Program to address emerging state and national concerns about lead poisoning among refugee populations. The Department and OTDA jointly conducted an assessment of educational needs for LHDs and refugee resettlement agencies, resulting in a collaboration to translate basic low literacy lead educational materials for refugees and to develop a new video for local agencies. The Department worked with the Office of Children and Family Services to develop and disseminate materials on lead poisoning prevention for all child care providers throughout New York State.

All providers funded by the Department are required to assess community need and develop outreach strategies to engage hard to reach populations into their services. Providers submit quarterly reports and, if data are available, Title V staff review to determine if high risk populations are being reached, and work with providers to address issues when necessary. Through programs such as the Immigrant Women's Health Program, the Department funds Family Planning Advocates on New York State to work with family planning agencies, to enable them to develop strategies for providing more culturally and linguistically competent, reproductive health services, thereby increasing their reach into the targeted population. Include in the updated standards for Medicaid Prenatal Care Prenatal care providers is the provision that they shall provide, or arrange for, the provision of health and childbirth education based on an assessment of the pregnant woman's individual needs. Prenatal care providers are required to focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and language needs of the patient as well as her gestational history.

The Department is also requiring funded providers to use, whenever possible, evidence-based or promising practices that have been tested or evaluated to produce desired outcomes on the target population. For example, in the upcoming comprehensive adolescent health request for applications, only evidence-based practices will be entertained for funding.
New York also has a comprehensive system of perinatal regionalization, led by Regional Perinatal Centers (RPCs). This better ensure women at high risk for poor birth outcomes are referred to a hospital that has the capability to care for the women and her infant. The Department also supports Regional Perinatal Forums, that bring hospital and community organizations together to identify gaps and barrier sin the service systems that may lead to poor birth outcomes.

Title V staff communicate regularly with Department regional staff as well as community providers. This allows issues such a lack of obstetrical coverage in certain areas of the state or issues with health outbreaks or medical coverage to come to the forefront. For example, Title V staff became aware of inadequate obstetrical coverage in a rural area of the state. Title V staff facilitated discussions among local partners, the Department's regional office and the state to address the issue.

The report also stressed the need for the Department to better coordinate the state's data system and information technology to streamline and coordinate the flow of information. Through New York's Office of Health Technology Transformation, New York's health IT plan is being advanced in the public's interest and with clinical priorities and quality and population health improvement goals leading the way. The plan includes key organizational, clinical and technical infrastructure as well as cross cutting consumer, financial and regulatory strategies to better coordinate data flow and information sharing. Within the DFH, staff are working on the development of the Child Health Information Integration Project (CHI^2) that aims to develop an integrated data system that will improve quality of care (via timely accurate data), reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life (e.g. immunizations) and enable bi-directional data sharing.

The Title V Director is also taking a lead role for the Department in the New York State Strategic Partnership facilitated by HRSA. The initial meeting was convened in May 12, 2009. Ten individuals representing divisions within the Department and the Community Health Care Association of New York State participated in this meeting. Health indicators for the two priority areas were identified as:
•The percentage of New York State residents with access to primary health care (coverage, workforce, medical home)
•The number and percentage of New York State residents with access to oral health care.

A follow-up meeting took place in November, 2009 to discuss the two priority health indicators, identified areas of concern, collaborative strategies, action steps and identified champions to ensure the work on the priority health indicators continued. The Bureau of Dental Health, in the DFH continues to work with the New York State Oral Health Coalition, and others to address access issues. In March, the Department submitted a report to the legislature titled "Increasing the Supply of Dentists, Midwives, Physician Assistants, and Nurse Practitioners in Underserved Areas Through Doctors Across New York Physician Loan Repayment Program Incentives".

Although there is much left to be done, the Department is committed to continue its work to ensure all New York's citizens receive high quality, comprehensive primary and preventive care to improve health outcomes.

B. Agency Capacity

The NYSDOH, as the Title V agency, plays a major role in assuring access to quality, comprehensive, community-based, family centered care for all NY's women, children and families. Title V provides the foundation for NY's commitment to develop and support core public health functions such as resource development, capacity and systems building, population-based functions such as public information and education, knowledge development, outreach and referral to services, technical assistance to local health departments and communities to address core public health needs, and training and resources to support a cadre of professionals necessary to meet the needs of New York's maternal and child health population. New York's strong commitment to ensuring the health and well-being of the MCH population is manifest in an extraordinary array of resources made available to meet their needs. This section provides an overview of these resources, which extend from the legal framework that authorizes the Department's work, to the extensive programming conducted on behalf of New York's most vulnerable populations.

1) NYS Statutes Relevant to Title V Program Authority and Impact Upon the Title V
NY's Public Health Law (PHL) provides a strong legal foundation for the Dept's efforts to promote and protect the health of mothers, infants and children. Some of the more salient aspects of the law relating to the MCH population are outlined below.

The functions, powers and duties of the Dept. and the powers and duties of the Commissioner of Health and other Dept. officers and employees are detailed in PHL Article 2, the Dept. of Health. The same article also details the mission of the Office of Minority Health, which is discussed below in the section devoted to cultural competency. Some important powers granted by the legislature to the Dept and the Commissioner include: supervision and funding of local health activities; the ability to receive and expend funds for public health purposes; reporting and control of disease; control and supervision of abatement of nuisances affecting public health; and, to serve as the single state agency for the federal Title XIX (Medicaid) program. Article 2 also provides that the Department shall also exercise all functions that, "…hereafter may be conferred and imposed on it by law."

Law governing the organization and operation of NY's local public health infrastructure, which includes the health departments of 57 counties and the City of NY, is contained in PHL Article 3, Local Health Organization. A major component of the Title V program capacity, these local health departments are supported by millions of state local assistance dollars, which the Department administers under the provisions of PHL Article VI, State Aid to Cities and Counties.

A key determinant of the Department's capacity to serve mothers, infants and children is PHL Article 7, FEDERAL GRANTS-IN-AID, which specifically authorizes DOH to, "…administer the provisions of the federal social security act or any other act of congress which relate to maternal and child health services, the care of children with physical disabilities and other public health work and to co-operate with the duly constituted federal authorities charged with the administration thereof." This provision not only empowers the Dept. to obtain and distribute Title V funds, but also those from Title X of the PHS Act, WIC nutrition and other federal resources essential to our efforts to improve the health of the MCH population.

The Dept's ability to control lead poisoning is conferred by PHL SS1370-1376-a, which defines the State lead poisoning program, specifies lead screening and reporting requirements, and prohibits the manufacture, sale and use of specific products containing lead. The law also details abatement requirements where lead hazards exist, identifies enforcement agencies, and provides remedies for failure to act to abate lead hazards.

The comprehensive tobacco control capacities of the Dept. are specified in PHL Article 13-E, regulation of smoking in certain public areas, which enables the Dept. to reduce environmental exposure to tobacco smoke by prohibiting smoking in most public places; PHL Article 13-F, regulation of tobacco products and herbal cigarettes; distribution to minors, which defines the

State tobacco use prevention and control program, prohibits free distribution of promotional tobacco and herbal cigarette products, and which prohibits sale of such items to minors.

PHL Article 21, Control of Acute Communicable Diseases, details the role of local health officials in control efforts, and specifies reporting requirements and patient commitment procedures. This Article also provides control requirements for specific diseases, including HIV, rabies, typhoid fever, poliomyelitis and Hepatitis C. PHL Article 23, Control of Sexually Transmissible Diseases, outlines the roles of state and local health officials in the identification, care and treatment of persons with a sexually transmissible disease specified by the Commissioner, and provides for the injunction and abatement of houses of prostitution.
Direct reference to the duties of the Commissioner of Health regarding the health needs for mothers, infant and children is made in PHL Article 25, Maternal and Child Health.

Succeeding sections in PHL Article 25 authorize the Commissioner to, among other important activities, screen newborns for inherited metabolic diseases (SS2500-a), HIV (SS2500-f) and hearing problems (SS2500-g). NY's Child Health Insurance Plan is detailed in PHL SS2510-2511, and the statewide Adolescent Pregnancy Prevention and Services (APPS) Program is authorized by PHL SS2515-2515-d. The Commissioner's extensive powers to affect prenatal care are enumerated in PHL SS2520-2529. An important asset to Departmental efforts to monitor, evaluate and improve patient care and outcomes is provided by PHL SS2500-h, which authorizes development and maintenance of a statewide perinatal data system and sharing of information among perinatal centers.

The Dept's Early Intervention (EI) Program, for children who may experience a disability because of medical, biological or environmental factors which may produce developmental delay, is authorized by PHL SSSS2540-2559-b, while programming to provide medical services for the treatment and rehabilitation of children with physical disabilities is authorized by PHL SSSS 2580-2584.

Nutrition programming conducted on behalf of children in day care settings is authorized by PHL SSSS 2585-2589, while PHL SSSS2595-2599 establishes the nutrition outreach and public education program to promote utilization of nutrition throughout the state. The makeup and operation of NY's Obesity Prevention Program is detailed in PHLSSSS2599-a-2599-d.

The ability of the NYS to regulate hospitals, including ambulatory health facilities, is conferred by PHL Article 28, Hospitals, and is a prime determinant of the Department's capacity to promote and protect the health of mothers and children. Among the specific provisions of the NYS Health Care Reform Act (HCRA), which is codified as PHL SSSS2807-j-2807-t. A major component of NYS Health Care financing laws, HCRA governs hospital reimbursement methodologies and targets funding for a multitude of health care initiatives. The law also requires that certain third-party payors and providers of health care services participate in the funding of these initiatives through the submission of authorized surcharges and assessments.

Similarly, the Department has been given broad powers to regulate home health care agencies and health maintenance organizations through PHL Article 36 and PHL Article 44, respectively. With increased interest in, and funding allocated to, maternal/newborn home visiting programs, the importance of Department's home health agency regulation has grown considerably Now that the majority of Medicaid-eligible mothers and children are enrolled in Medicaid managed care plans, NYSDOH relies on its delegated powers to ensure the quality of care rendered to them.

The broad authority and reach provided through these and other state laws empowers the Department to plan, implement and oversee a variety of programs focused on improving the health and wellness of the mch population.

2) Capacity to Provide Preventive and Primary Care Services for Pregnant Women, Mothers, Infants and CSHCNs

NYSDOH oversees a broad array of programs designed to address the needs of pregnant women, mothers, infants and CSHCNs. Descriptions of the major TitleV-related efforts are provided below.

Family Planning Program provides accessible reproductive health services in 53 agencies in 197 sites. Programs provide low-income, uninsured women with contraceptive education, counseling and methods to reduce unintended pregnancies and to improve birth spacing and outcomes. The program serves over 335,000 women per year. The Family Planning Extension Program, added in 1998, provides up to 26 months of additional access to family planning services for women who were pregnant while on Medicaid, and subsequently lost Medicaid coverage. The Family Planning Benefit Program began in October 2002 and provides Medicaid coverage for family planning services to individuals with incomes at or below 200 percent of the federal poverty level.

Comprehensive Prenatal-Perinatal Services Networks are community-based organizations that mobilize the service system at the local level to improve perinatal health. The scope of service provided by these networks includes coalition building, conducting outreach and education to high-risk populations, and provider education on special topics, such as screening for substance abuse among pregnant women, or cultural sensitivity. Each of the 16 perinatal networks targets a region, ranging in size from several health districts in NYC to large multi-county regions in rural upstate.

Community Health Worker Program (CHWP) - In 23 programs statewide, one-on-one outreach, education and home visiting services are provided to pregnant women who are at highest risk for poor birth outcomes, such as low birth weight infants or infant mortality. The CHWP is targeted towards specific communities with high rates of infant mortality, out-of-wedlock births, late or no prenatal care, teen pregnancies and births, and births to low-income women.

Healthy Mom/Healthy Baby is designed to improve the health of mothers and infants through the development and implementation of organized county systems of perinatal health and home visiting services. Six Local Health Departments (LHDs) in the highest need areas of the state receive funding to plan and develop a system of perinatal health and home visiting services, outreach and identification, home visiting for high-risk pregnant/postpartum women, and improved access to related health and human services. The program seeks to improve pregnancy outcomes and infant health and development by identifying high-risk pregnant women and postpartum women and their newborns, assessing their need for services, and assisting them in obtaining appropriate services, including home visiting.

Nurse Family Partnerships (NFP) is an evidence-based home visiting program that improves the health and self-sufficiency of low-income, first time parents and their children. NFP is a nurse-led model in which nurses promote the personal health of mothers, parental care of the child, environmental health, support systems for mother and infant, and parent's life course development. The Office of Temporary and Disability Assistance provided NYSDOH with up to $5,000,000 in federal TANF funding via a Memorandum of Understanding to expand NFP programs. The three approved programs funded to provide services are: the NYC Department of Health and Mental Hygiene, Onondaga DOH and Monroe County DOH Nurse Family Partnership Programs. The OHIP has also obtained state plan approval to provide Medicaid funding support to two of these programs in Monroe County and New York City as targeted case management programs.

Regional Perinatal Centers (RPC) - NYS's system of regionalized perinatal services includes a hierarchy of four levels of perinatal care provided by the hospitals within a region and led by a RPC. The regional systems are led by RPCs capable of providing all the services and expertise required by the most acutely sick or at-risk pregnant women and newborns. RPCs provide or coordinate maternal-fetal and newborn transfers of high-risk patients from their affiliate hospitals, and are responsible for support, education, consultation, and improvements in the

quality of care in the affiliate hospitals within their regions. RPC quality assurance activities are supported by the Statewide Perinatal Data System that provides affiliate hospital data to them. There are currently 139 birthing hospitals, including: 60 Level 1 hospitals; 25 Level 2 hospitals; 36 Level 3 hospitals; and, 18 hospitals constituting 16 RPCs

Regional Perinatal Forums, involving hospital and community stakeholders, were established in each region to identify and address perinatal health issues on the local level. Forums are configured to bring a regional perspective to perinatal care statewide, and encompass all regions of the state.

Newborn Hearing Screening Program (NBHS) - Since October 2001, all facilities caring for newborn infants are required to have in place a newborn hearing screening program to conduct hearing screenings all babies born in NYS, and to refer for further evaluation and follow-up services when necessary.

Medicaid Prenatal Care provides comprehensive prenatal care for women up to 200% of the fpl based on in accordance with current standard of obstetrical care. The Medicaid Obstetrical and Maternal Services (MOMS) Program was developed to provide comprehensive prenatal care services to low-income women in rural settings. Prenatal care is provided in doctors' offices, while ancillary services such as health education, psychosocial and nutritional screening are provided by qualified Health Supportive Services Providers. Over 3,000 physicians are enrolled in the MOMS program. The Title V programs works closely with the OHIP to ensure women across NYS have access to prenatal care services.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental food, participant-centered nutrition education/counseling, breastfeeding support, and linkages with health and social services for low-income eligible women and children at no cost. WIC's purpose is to improve pregnancy outcomes, promote optimal growth and development for infants and children and influence lifetime nutrition and health behaviors. The NYS WIC program provides services via 94 local agency direct service providers at over 450 WIC clinic sites.

Tobacco Control Program is a comprehensive, coordinated program that seeks to prevent initiation of tobacco use, reduce current use of tobacco products, eliminate exposure to secondhand smoke and reduce the social acceptability of tobacco use. The program consists of community and statewide activities supported by surveillance and evaluation. NYSDOH issues grants for programs such as local tobacco control, youth action, tobacco enforcement and prevention, and cessation. The NYS Smoker's Quitline (1-866-NY QUITS (1-866-697-8487)) continues to be a key evidence-based component of the program's cessation efforts.

School-Based Health Center Program (SBHC) -- Through more than 220 SBHCs sponsored by 55 community health and mental health services providers, the SBHCs provide primary and preventive medical and mental health care services to more than 170,000 students living in high-need areas. SBHCs are extension clinics of Article 28 hospitals and/or diagnostic and treatment centers that provide services in school settings.

School-Based Health Center Dental Program ensures those students with limited or no access to care may have access to preventive dental care through SBHC dental sites. The program provides dental services with mobile vans, portable equipment or in a fixed facility within the school. Students are enrolled with parental consent. Where applicable, the SBHC Dental Program works with the students' primary dental providers to coordinate services and referrals.

Preventive Dentistry for High-Risk Underserved Populations Program addresses the problems of excessive occurrence of dental disease among children who reside in communities with a high proportion of persons living below 185 percent of the federal poverty level. The application of dental sealants, an extremely effective caries-prevention agent, in combination with a program of

dental screening, referral and other preventive services significantly improves the dental health of children in underserved communities. Thirty-one projects provide preventive dental services to an estimated 260,000 children and 12,000 pregnant women in underserved areas across the state. Organizations providing preventive dental services under this program include LHDs, dental schools, hospitals and diagnostic and treatment centers, rural health networks and SBHCs.

Supplemental Fluoride Program is a school-based fluoride mouth rinse program, which serves elementary school children and includes a preschool preventive tablet program that serves three- and four-year-olds in Head Start centers in fluoride-deficient areas. More than 120,000 children are participating in these programs.

Child and Adult Care Food Program (CACFP) improves the nutritional quality of meals and snacks served in participating day care programs by establishing minimum standards for items served, providing reimbursement for qualifying meals and snacks, and mandating ongoing monitoring of food service programs and training of program staff. The goal of CACFP is to ensure that nutritious and safely prepared meals and snacks are available to children age 18 and under and to functionally impaired adults and senior citizens participating in eligible day care programs.

Eat Well Play Hard in Child Care Settings (EWPHCCS) is an obesity prevention program that targets low income child care centers. EWPHCCS improves the nutritional and physical activity environments in child care, and educates pre-school children, their families, and child care center staff on how to adopt healthy lifestyle behaviors.

Eat Well Play Hard Community Projects - In 1997, the NYSDOH initiated the Eat Well Play Hard (EWPH) intervention targeting pre-school aged children, their families and their communities in an effort to address the growing obesity epidemic. The overall goal of EWPH is to prevent childhood overweight and reduce long-term risks for chronic disease through promotion of targeted dietary practices and increased physical activity beginning at age two. The strategies of EWPH target more than 500,000 children over the age of two and have been incorporated into the food delivery and nutrition education components of all division programs. EWPH is expanding through partnerships with state agencies and other organizations concerned about the health of children in NYS.

Overweight and Obesity Prevention Program was established to increase physical activity and improve nutrition among residents of NYS. The program's current primary focus is the prevention of childhood obesity. The program distributes funding for three Centers for Best Practices to address age-specific overweight and obesity prevention issues; School and Community Partnerships; and, a statewide organization to provide training, consultation, support and guidance to child care center staff to improve nutrition, increase physical activity and decrease television/media use.

Diabetes Prevention and Control - To address the diabetes epidemic, the Diabetes Prevention and Control Program (DPCP), in collaboration with members of the NYS Diabetes Task Force, developed and released the NYS Plan for the Prevention and Control of Diabetes in 2003. To address the priorities established in the plan, the DPCP established five Diabetes Centers of Excellence to serve as NYS's premier hospital-based diabetes specialty centers. The centers incorporate current science into comprehensive, integrated and multi-disciplinary collaborative approaches for the prevention, early diagnosis and treatment of pre-diabetes and diabetes. The DPCP, in collaboration with a group of type 1 diabetes stakeholders, is developing a new Diabetes Training Manual for Schools. The manual will include a standardized curriculum for school nurses to use in training non-licensed school personnel in basic diabetes care tasks and in the emergency administration of glucagon.

Childhood Asthma Coalitions - 11 Regional Childhood Asthma Coalitions, reaching almost all counties and high risk neighborhoods, are organized groups of leaders in community

organizations and volunteers within a specific region who work together to improve the quality of care and the quality of life for children and families with asthma.

Immunization Program works to prevent the occurrence and transmission of vaccine-preventable diseases by ensuring the delivery of vaccines to children and adults. The program assures that: all children have access to vaccines irrespective of financial status; adequate vaccine supplies are available for all primary health care providers; and that health care providers are aware of immunization standards of practice.

Child Mortality Review/SIDS Prevention Program - In collaboration with other state agencies, the program is working to develop a more comprehensive statewide child death review initiative that will further expand the understanding of why children die, and will apply those findings to improve prevention activities. In addition, the program provides bereavement support services and training for emergency service personnel and other first responders. The program also provides public outreach and education about risk factors associated with SIDS.

Lead Poisoning Prevention Program (LPPP) - The goal of the LPPP is to reduce the occurrence and consequences of childhood lead poisoning throughout the state. The department, in collaboration with a wide range of partners, has developed a strategic plan for the elimination of childhood lead poisoning in NYS by 2010.
Children with Special Health Care Needs (CSHCN) Program works closely with internal partners and LHDs, community-based and professional organizations to develop and implement systems initiatives to improve quality of services for children with special health care needs. The CSHCN Program has 56 contracts with LHDs to provide services to children with special health care needs birth to 21 and their families. With funding and technical assistance from the department, the local CSHCN Programs develop community-based resources to: assist families in accessing necessary health care and related services; promote "medical homes" for the provision of high-quality health care services that meet the needs of children and families; and, develop partnerships with families of children with special health care needs that involve them in program planning and policy development.

The CSHCN Program, in conjunction with the department's Wadsworth Laboratories' Newborn Screening Program, oversees a statewide network of specialty centers that accept referrals of infants with positive newborn screens for endocrine, metabolic, cystic fibrosis or hemoglobinopathy disorders.

Physically Handicapped Children's Program (PHCP) operates in most counties in NYS. The program provides reimbursement for specialty health care for severe chronic illness or physically handicapping conditions in children. Medical equipment, office visits, hospitalizations, pharmaceuticals, and other health-related services can be reimbursed for children meeting county financial and medical eligibility criteria.

Early Intervention Program (EIP) is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. To be eligible for services, infants and toddlers must have a delay in one or more areas of development (physical growth or development, learning skills, speech and language development) or a physical or mental diagnosis that impacts on development (such as cerebral palsy or Down syndrome). The EIP, created in 1993, currently provides services to more than 70,000 infants and toddlers and their families statewide.

Dental Rehabilitation Program (DRP) provides children with physically-handicapping malocclusions access to appropriate orthodontic services. Operated in most LHDs under the auspices of the PHCP, the DRP provides both diagnostic/evaluative and treatment services. The program is open to children under the age of 21 who have congenital or acquired severe malocclusions. Over 10,000 children receive services annually.

Preventive Dentistry Program for Deaf/Adolescent Children is operated under contract with Bellevue Hospital in NYC and provides health education and treatment services for deaf children seen at the Bellevue dental clinic and at nearby schools for deaf children in Manhattan. During 2000, dental services were provided for more than 341 deaf patients at the Bellevue clinic, and 271 deaf students participated in a preventive dental program established at P.S. 47, School for the Deaf.

3) Capacity to Provide Culturally Competent Care

The NYS Office of Minority Health (OMH) was established by an amendment to the NYS PHL in 1992 and became operational in 1994. PHL SS 240-243 outlines the duties and responsibilities of the office, responsibilities and membership appointments of the NYS Minority Health Council, and specifies the contents of a minority health report which NYSDOH is required to prepare and distribute biennially.

Unequal access to high quality health care is a problem that has been documented for many racial and ethnic minorities. It has also been shown that when access is available, many populations face barriers which prevent them from utilizing health care. Programs funded under the NYS OMH help to reduce health care system access barriers for racial and ethnic minorities. In 1999, OMH created the State-Community Partnerships Program for minority health improvement in high need areas. Through this coalition-focused, asset-based, neighborhood-specific program, twenty-three community coalitions have been funded to address community-specific health disparities. Using the Spectrum of Prevention framework (this framework is made up of six complementary levels to effect community level change: strengthening individual knowledge and skills; promoting community education; educating providers; fostering coalitions and networks; changing organizational practices; and influencing policy legislation), these coalitions work to impact minority health on all six levels. The current cohort consists of three community coalitions providing services in Westchester, Manhattan and Onondaga counties. The Latino Health Outreach Program began in 2007. It provides outreach opportunities to engage more Latinos in the health care system. Populations being served by the four projects across NYS include Latinos across the life cycle (children, adolescents, adults and seniors) who are not engaged at all, or engaged sporadically, with the health care system, and immigrants from countries where Spanish is the primary language.

As a follow-up to the Minority Health Disparities Conference in 2009, OMH initiated a webinar series to spotlight minority populations in NYS. The webinars, which featured presenters with practical experience designing and implementing programs with the minority group highlighted, were scheduled as follows: April 15 (Asian Americans); May 12 (American Indians); May 20 (African Americans); May 26 (Hispanics/Latinos). A major focus of the Prevention Agenda is to ensure all New Yorkers have access to quality health care and ethnic and racial disparities can be addressed. In April, 2010, local health departments and Department experts in specific topic areas (teen pregnancy prevention, prenatal care, obesity prevention) met to discuss local strategies to improve health outcomes and address disparities in selected health outcomes. These discussions focused on local public and private agencies that could partner to address specific issues, and evidence-based interventions and promising practices to address health issues, including health disparities. Title V staff will continue to promote partnerships to improve the health outcomes of New York's diverse community.

The Department is also making a concerted effort to provide services and resources to the highest need areas of the state. For example, although New York's outcomes in many areas are improving, in areas such as adolescent pregnancy, disparities continue to exist due to increasing numbers of immigrant and hard to reach adolescents. Extensive data analyses have been completed to target the highest need areas and provide better utilization of resources. The Department also provided statewide training to current and potential providers on evidence based

programming and community coordination of resources, and outreached to providers in the hardest to reach areas to ensure there will be a pool of agencies positioned to apply for funds to address the need in the highest need areas of the state. In addition, all requests for applications now specifically identify high risk groups as a priority including specific minority populations, youth in foster care or those otherwise not engaged in the service system. All programs developed by the Bureaus and Divisions within the Center for Community of Health work with the communities they serve to assure that their programs meet community needs. In addition, the following processes help to ensure ongoing improvements in cultural competency:

The Request of Applications process used to select contractors requires applicants to demonstrate competence in serving the target populations including linguistic and cultural competency.

- The Department provides programs with health risk data, enabling programs to tailor their programs to the community. Data are provided by major race/ethnicity categories, when available, and at the lowest feasible geographic unit, e.g., zip code.
- All programs are required to include outreach plans and activities to ensure the services are reaching the high risk, diverse populations in their catchment areas. This includes the LHD CSHCNs programs as well.
- The Child Health Information Integration Project (CHI^2) that aims to develop an integrated data system that will improve quality of care, reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life (e.g. immunizations) and enable bi-directional data sharing. Ultimately health care providers will have access to child health information to ensure they have a complete picture of the child's health history and needs, which will benefit those high risk children who may access health care through a variety of settings and clinics.
- Programs use community-based organizations with diverse staff, representative of the racial and ethnic backgrounds of the communities.
- Programs that serve non-English speaking populations must have staff to deliver services who are fluent in the predominant foreign languages spoken in the community and/or provide access to a telephone language line.
- Programs are encouraged to hire staff that is from communities and populations served. For example, the CHWP uses paraprofessional home visitors indigenous to the communities and populations served.
- The Department funds Family Planning Advocates of New York State to work with family planning agencies, to enable them to develop strategies for providing more culturally and linguistically competent, reproductive health services, thereby increasing their reach into the targeted population.
- Written and outreach materials are translated, adapted and/or provided in alternate formats based on the needs and preferences of the population served.
- Programs actively engage the community on an ongoing basis. The School-Based Health Center program, for example, has a community advisory council that assures that the views of the community members are reflected in the SBHC polices priorities and plans. The Comprehensive Prenatal Perinatal Networks have community coalitions that include community organizations, including individuals from the community served to guide program outreach and development.

C. Organizational Structure

This section reviews the general format of New York State government and provides further details regarding the placement of the Title V program within the NYSDOH and its constituent components as they relate to the administration of New York's Title V Program. Significant detail regarding the placement of the Title V program within the NYSDOH is contained in Section III.A.

The structure of the government of NYS mirrors that of the federal government, with three independent branches. The legislative branch consists of a bicameral Legislature, including a 62 member Senate and 150 member Assembly representing the nearly 20 million citizens of the

State. All members are elected for two-year terms. The judicial branch comprises a range of courts (from trial to appellate) with various jurisdictions (from village and town courts to the State's highest court - the Court of Appeals). The Judiciary functions under a Unified Court System, which has responsibility for resolving civil claims, family disputes, and criminal accusations, as well as providing legal protection for children, mentally-ill persons and others entitled to special protections. The executive branch consists of 20 departments that is the maximum number allowed by the State Constitution. The New York State Department of Health is one of those 20 departments.

Only four statewide government officers are directly elected including:
- The Governor, who heads the Executive Department, and Lieutenant Governor (who are elected on a joint ballot).
- The State Comptroller, who heads the Department of Audit and Control.
- The Attorney General, who heads the Department of Law.

With a few exceptions, the Governor appoints the heads of all State departments and agencies of the executive branch. One important exception is the Commissioner of the State Education Department, who is appointed by and serves at the pleasure of the State Board of Regents.

Geographically, New York State is divided into 62 counties (five of which are boroughs of New York City). Within these counties are 62 cities (including New York City), 932 towns, 556 villages and 697 school districts. In addition to counties, cities, towns and villages, more than a thousand "special districts" meet local needs for fire and police protection, sewer and water systems or other services. Local governments are granted the power to adopt local laws that are not inconsistent with the provisions of the State Constitution or other general law.

Under the direction of the Commissioner, Richard F. Daines, M.D., who is appointed by the Governor, the Department meets its responsibilities through the Office of Health Insurance Programs, the Office of Long Term Care, the centers located in the Office of Public Health, and the Office of Health Systems Management. The Office of Health Insurance Programs is responsible for Medicaid, Family Health Plus, Child Health Plus, Elderly Pharmaceutical Insurance Coverage, and the AIDS Drug Assistance Program. The Office of Long Term Care oversees the integration of planning and program development for services related to long term care. The Office of Public Health and the Office of Health Systems Management provide policy and management direction to a system of regional offices, whose staff conduct health facility surveillance, monitor public health, provide direct services and oversee county health department activities. Additionally, the Department is responsible for five health care facilities. The Department has a workforce of 5,479 positions, with 28 percent of those positions employed in the Department's health care facilities.

The Office of Public Health (OPH), led by Guthrie Birkhead, MD, MPH, brings together all Department public health programs under one organizational mantle. The Office's programs include: the biomedical research, public health science, and quality assurance of clinical and environmental laboratories of the Wadsworth Center; the counseling, education, prevention, health care and supportive services of the AIDS Institute; the protection of human health from environmental contaminants in air, water and food through regulation, research and/or education by staff of the Center for Environmental Health; the nutrition, health screening, immunization, tobacco control, maternal and child health programs and the public health surveillance and disease control activities of the Center for Community Health.; the support and oversight of local health departments and the efforts to help build public health workforce capacity of the Office of Public Health Practice; and, the comprehensive all-hazards preparedness and response activities of the Office of Public Health Preparedness.

The programs providing services to the mch population are spread throughout the Department, but are mainly focused in the Center for Community Health (CCH). CCH responsibilities touch practically every aspect of public health in NYS. Under the direction of Ellen Anderson, MS, the

Center conducts programming through four Divisions: the Division of Chronic Disease and Injury Prevention; the Division of Nutrition; the Division of Epidemiology; and, the Division of Family Health. Each addresses a major component of the Department's public health mission, and all are involved in carrying out MCHSBG-related activities. The Office of Minority Health also resides within the Center, and plays a key role ensuring that Department programs address population health disparity issues.

The Division of Family Health, directed by Barbara L. McTague (who also serves as the Director of the NYS Title V Program), promotes the health of families by assessing needs, promoting healthy behaviors and providing services to support families. The division's primary focus is to improve the health of women, children and adolescents. Its programs touch new mothers, adolescents, children with disabilities, rape victims and children with lead poisoning or lack of access to dental services. Programs promote healthy behaviors while also assuring access to quality health care. The division provides access to primary medical and dental care and preventive health services for migrant farmworkers and Native Americans living in reservation communities. The Division provides the central focus for New York State's Title V MCH programming, and consists of three program bureaus and the Office of the Medical Director:

The Bureau of Maternal and Child Health, directed by Rachel M. de Long, M.D., M.P.H., administers a variety of programs that focus on the prevention of adverse health conditions and promotion of health and wellness in women, children and youth. The newly formed BMCH is organized as follows:
- Clinical Services Section is comprised of Article 28-based programs and initiatives that support the direct delivery of clinical health care services to achieve outcomes related to the accessibility, quality, and sustainability of health care services for children and families. These programs have substantial commonalities in terms of regulatory oversight, certification, monitoring, clinical quality improvement, health and safety standards, and reimbursement and sustainability. Consolidating these programs within a common section facilitates the establishment and implementation of more consistent and effective systems and standards to address these common issues. Programs are organized within three units:
o School-Based Health Center Program.
o Family Planning and Reproductive Health Care Program.
o Hospital Services initiatives including:
  - Perinatal Regionalization, including Regional Perinatal Centers and affiliate hospitals, Regional Perinatal forums, and the National Initiative for Children's Healthcare Quality (NICHQ) project.
  - Infertility Demonstration Program
  - Hospital Sexual Assault Forensic Examiner (SAFE) program
  - Osteoporosis Prevention and Education.
- Community-Based Prevention Section is comprised of non-clinical community-based programs that focus on prevention and health promotion strategies to achieve outcomes related to healthy behaviors and health outcomes at the personal, family and community levels. These programs have substantial commonalities in terms of primary and secondary prevention strategies, emerging federal priorities and funding opportunities, and local partnerships to promote and improve health. Consolidating these programs supports the infusion of a positive developmental life-course approach and the use of evidence-based prevention strategies across programs, allows for alignment and ongoing meaningful collaboration between programs with similar target groups and outcomes, and facilitates the establishment and implementation of more consistent systems for program management and improvement. Within this section, programs are organized within two units, each containing several specific programs and/or initiatives:
o Perinatal Health unit that includes the following programs/initiatives:
  - Community Health Worker (CHW) Program
  - Healthy Mom, Healthy Baby home visiting
  - Nurse Family Partnership
  - Comprehensive Prenatal Perinatal Services Networks
  - Growing Up Healthy Hotline

o Adolescent Health that includes the following program/initiatives:
  - Comprehensive Adolescent Pregnancy Prevention (CAPP), including the current CBAPP and APPS programs
  - Teenage Services Act (TASA), in conjunction with Office of Health Insurance Programs
  - ACT-for Youth Center of Excellence
  - Sexual Violence.
- Child Health Unit that is comprised of programs and activities related to child health programs and outcomes. It also includes several cross-cutting child health-related activities and initiatives that support delivery of information to families and consumers and/or the integration of child health promotion practices across a range of other local child-serving settings (e.g. early care and education). Specific programs and initiatives within the unit include:
o Lead Poisoning Prevention Program;
o Children with Special Health Care Needs;
o Physically Handicapped Children's Programs; and,
o Other cross-systems early childhood initiatives, including parenting education projects and the current federal Project LAUNCH grant. Consistent with the framework for public health MCH services, these programs and activities are characterized by a blend of public health approaches including population-based public and professional outreach and education, targeted care coordination and other enabling services, and gap-filling direct health care services.
- Data Analysis, Research and Surveillance Unit that consolidates the data systems, research and data analysis activities and staff currently housed within individual programs, including the Statewide Perinatal Data System, Rape Crisis program data system, and LeadWeb childhood lead registry. Consolidating these functions within a single unit facilitates important peer support between research staff and promotes consistent approaches to use of data to support ongoing program development, implementation and evaluation.

The Bureau of Early Intervention, directed by Bradley Hutton, MPH, is responsible for two major programs for young children with, or who may be at risk for, physical and cognitive disabilities. The EIP is a statewide service delivery system for infants and toddlers (birth to three years) with disabilities and their families. Its mission is to identify and evaluate those children whose healthy development is compromised and provide appropriate interventions to improve child and family development. The Bureau also administers the Department's Newborn Hearing Screening Program.

The Bureau of Dental Health, under the leadership of Jay Kumar, DDS, MPH, implements and monitors a broad range of statewide dental health programs that prevent, control and reduce dental diseases and other oral health conditions, and promote healthy behaviors. In addition to maintaining the focus on children, programs promote dental health among adult populations. The Bureau's dental health programs include:
- Preventive Dentistry for High-Risk Underserved Populations Program
- Supplemental Fluoride Program
- Dental Rehabilitation Program
- Preventive Dentistry Program for Deaf/Adolescent Children
- Dental Health Education
- Dental Public Health Residency Program
- Research and Epidemiology
- State Oral Disease Prevention Program
- School-Based Health Center Dental Program
- Targeted Oral Health Service Systems for Women and Young Children Program

The Office of the Medical Director provides medical leadership for the DFH. Under the direction of Marilyn Kacica, MD, MPH, physicians in the office provide medical consultation and support to all division programs; support policy development and programmatic initiatives; participate in quality improvement initiatives and provide advice on emerging medical issues. OMD programs include:
- Child Mortality Review/SIDS Prevention Program
- American Indian Health Program

- Migrant and Seasonal Farmworker Health Program
- MCH Epidemiology Program
- Statewide Systems Development Initiatives.

An attachment is included in this section.

D. Other MCH Capacity

As stated previously, the DFH has responsibility for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives. There are currently 207 filled Title V-funded positions within NYSDOH, with an additional 613 non-Title V-funded positions performing Title V-related activities. Positions are located within NYSDOH's central, regional and district offices. Staff cover the full range of MCH activities, including child and adolescent health, women's health, sexual violence prevention, perinatal health, oral health, local health services, nutrition, child safety, injury control, laboratory operations, human genetics, congenital malformations, data and information systems infrastructure, health communications, managed care and facility surveillance.

Barbara McTague is the Director of the DFH and Director of the NYS Title V Maternal and Child Health Services Program in the NYSDOH. Ms. McTague provides policy and program direction and administrative oversight for the Division's bureaus, including the newly formed Bureau of Maternal and Child Health, incorporating the Bureau of Women's Health and the Bureau of Child and Adolescent Health, the Bureau of Dental Health, the Bureau of Early Intervention and the Office of the Division's Medical Director which includes the Migrant Health and Indian Health Programs. Employed by NYSDOH since 1987, she has managed several programs and Bureaus. While in the AIDS Institute, she developed, implemented and managed a number of innovative, new public health programs related to the prevention and treatment of HIV, including: the AIDS Drug Assistance Program, women's HIV counseling, testing and supportive services, the Substance Abuse Initiative, which provides the full continuum of HIV services in substance abuse treatment settings, including the development of needle exchange programs. In 1996, Ms. McTague became the Director of the Bureau of Women's Health, where she managed the statewide family planning program, including development and implementation of Medicaid waiver programs to expand access to family planning services, as well as Department's initiatives related to adolescent pregnancy prevention. In addition, she developed programs related to violence against women, including standards of hospital care for victims of sexual assault. Ms. McTague also spearheaded a perinatal regionalization initiative which resulted in significant changes in the perinatal health services arena, including the development of a statewide perinatal data system and significant improvement in the regionalized system of perinatal care. She has also directed the Bureau of Early Intervention, the statewide service delivery system for toddlers with disabilities. During her tenure, she led a significant effort to clearly articulate program policies and goals and to standardize and improve the quality of program performance. Ms. McTague has made considerable contributions to improving the health of women, children and adolescents throughout NYS.

Wendy Shaw, M.S., B.S.N., has served as Associate Director of the DFH since August, 2007. She previously served as the Director of the Bureau of Women's Health (BWH) and maintains her clinical skills as a labor and delivery nurse at a local area hospital. Ms. Shaw served as Director of the Perinatal Health Unit within the BWH from 2000 through 2002, when she became Assistant Director. Her previous experience in the Early Intervention program provides her with further valuable knowledge in her role within the DFH.

Helen Rodriguez Burmaster coordinates Title V Maternal and Child Health Services Block Grant

application development, submission, grant management activities and special projects for the DFH. Ms. Burmaster has over 30 years of experience working in NYS government, administering programs providing for the health and well-being of NY's children and families. Within the DFH, she recently served as Assistant Director for the Bureau of Dental Health and Assistant Director of the Fiscal Unit for the DFH. Helen also served as the Deputy Director for the Office of Minority Health, and served in the NYS Division of the Budget developing and implementing the Governor's financial plan and budget for agencies serving children and families. She also served as staff to the NYS Commission for National and Community Service, administering the State's AmeriCorps programs. Helen also worked as the WIC Program Director at the Whitney M. Young Community Health Center in Albany.

Under the direction of Marilyn Kacica, M.D., M.P.H., the Office of the Medical Director provides leadership and collaborates closely with the Bureaus in the Division. Dr. Kacica is a graduate of St. Louis University and received her M. D. from the St. Louis University Medical School. She completed pediatric residency training at the Cardinal Glenon Children's Hospital, subspecialty training in pediatric infectious disease at the Children's Hospital of Cincinnati, and her preventive medicine residency at NYSDOH. Her M.P.H. was awarded from the State University of New York at Albany, School of Public Health, where she is currently a Clinical Associate Professor of Epidemiology. She is board-certified in Pediatrics and is a fellow of the American Academy of Pediatrics. Prior to moving to the DFH, she served as the Director of the Healthcare Epidemiology Program in the Division of Epidemiology's Bureau of Communicable Disease Control. She is providing leadership on a myriad of clinical, epidemiological, data utilization and quality improvement issues within the Division, was the co-chair of the AMCHP Emergency Preparedness Committee as well as the Adolescent Health Committee of the Emerging Issues Committee. This past year, she was appointed to be the Vice Chair of the Emerging Issues Committee. She leads preparedness efforts being made on behalf of NY's maternal and child health population. Dr. Kacica serves as the Principal Investigator (PI) to the State Systems Development Initiative and the NBS Effective Follow-up grants. In addition, she is the Program Director for the NYSDOH's Child Health Integration Initiative which is focusing on the integration of child health information for both public health and provider benefit. She is also leading quality improvement initiatives focusing on School-based health centers and perinatal health.

Christopher Kus, M.D., M.P.H., serves as Associate Medical Director for the DFH, and is a pediatric consultant to the Division. He is a graduate of Michigan State University and the Wayne State University School of Medicine. He received his M.P.H. from University of North Carolina at Chapel Hill. He is a developmental pediatrician who worked with the New Hampshire and Vermont Departments of Health prior to coming to NY. He has been with the NYSDOH for over ten years. A board-certified pediatrician and a fellow of the American Academy of Pediatrics, Dr. Kus is a Past President of the Association of Maternal Child Health Programs (AMCHP). He serves as co-chair of the AMCHP Legislative and Finance Committee. He was a member of the Early Childhood Expert Panel involved in developing the Third Edition of Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (2008). Dr. Kus serves as the Association of State and Territorial Health Officials (ASTHO) liaison to the HRSA Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC).

New York's State Systems Development Initiative (SSDI) grant is coordinated by Ms. Cathy Tucci-Catalfamo in the Office of the Medical Director. The goal of the SSDI grant is to foster an infrastructure to improve data linkages among multiple data sources for child health information to assure program and policy development for material and child health. Ms. Tucci-Catalfamo has worked for the NYSDOH for over 30 years and has many years of experience in public health. She has worked for various bureaus and units within the DOH including the Cancer Control Bureau, Division of Occupational Health, Bureau of Injury Prevention, Bureau of AIDS Epidemiology, Bureau of Child and Adolescent Health, Division of Family Health and Bureau of Dental Health. Ms. Tucci-Catalfamo has assisted the NYSDOH Children with Special Health Care Needs Program to develop a data system and in gathering parent and consumer input for the MCHSBG needs assessment. SSDI staff will continue to play a key role in the CHI2 Project as

well as other programs to assist Title V with building data linkages and infrastructure.

Rachel de Long, M.D., M.P.H., has served as the Director of the Bureau of Child and Adolescent Health at the NYSDOH since 2005. Prior to this role she served as the Bureau's Medical Director from 2003 to 2004. Dr. de Long also serves on the faculty of the SUNY at Albany School of Public Health in the Department of Health Policy, Management, and Behavior. She earned a B.S. in Rural Sociology from Cornell University, M.D. from University of Wisconsin Medical School, and M.P.H. from SUNY Albany School of Public Health. She completed a medical internship in Family Practice at the Guthrie Clinic and residency training in Preventive Medicine at SUNY Albany/NYSDOH, and is Board-Certified in Preventive Medicine and Public Health. As Bureau Director, she has overall responsibility for developing, implementing and evaluating policies and programs related to a range of child and adolescent health issues. She serves as PI for several major child health related federal grants.

Susan Slade, RN, MS, is a very experienced clinical and public health nurse and public health administrator. She has worked in the NYSDOH since 1987, with over ten years of that time in the Bureau of Maternal and Child Health (formerly the Bureau of Child and Adolescent Health). As the manager of the Bureau's Child health Unit, Ms. Slade oversees several public health programs as well as non categorical activities related to health care provider and parenting education. In addition to being a licensed Registered Nurse, Ms. Slade is also a Certified Health Education Specialist.

Ruth Walden is a Public Health Representative 3 in the Bureau of Maternal and Child Health where she serves as a Family Specialist with the Children with Special Health Care Needs (CSHCN) Program. She manages the program's local health department contracts. As a Family Specialist, Ms. Walden provides a family perspective on CSHCN program and policy developments and supports and facilitates family and youth involvement in the program. Ruth has been involved in AMCHP as a "parent leader" for the last 10 years.
Jayanth Kumar, DDS, MPH, is the Acting Director of the Bureau of Dental Health. He has served the Department since 1980 and most recently as Director of the Research and Epidemiology unit of the Bureau of Dental Health. He is also Associate Professor, School of Public Health, University at Albany. Dr. Kumar is a board-certified specialist in dental public health and a former director and president of The American Board of Dental Public Health. He has served as a consultant to many national and international organizations including the Centers for Disease Control & Prevention (CDC), National Institute of Dental & Craniofacial Research, NIH, Health Resources Services Administration (HRSA), the American Dental Association (ADA) and the National Research Council (NRC). He is project director for the Centers for Disease Control & Prevention's co-operative agreement to strengthen state's infrastructure. Dr. Kumar oversees the Department's fluoridation and other public health dental programs targeting high-risk underserved women and children, the supplemental fluoride program for preschool and school-aged children residing in non-fluoridated areas of the State, the Dental Rehabilitation Program for children with physically-handicapping malocclusions. Other Bureau activities and programs include Dental Health Education, the Dental Public Health Residency Program, research and epidemiology, the oral health initiative, and targeted oral health service systems for women and children.

Bradley Hutton has been with the Department for fifteen years, serving as the Director of the Bureau of Early Intervention for the last three years. As Director, Brad oversees a team of 50 staff with responsibility for the administration of New York's Early Intervention Program which serves more than 70,000 infants and toddlers with disabilities or developmental delays each year. Previously, Brad directed the Department's Cancer Services Program for six years. He has served on several committees that advise the Centers for Disease Control and Prevention on cancer control and also served on the Institute of Medicine's Committee to Improve Mammography Quality due to his leadership role in identifying and improving the quality of mammography in NY.

E. State Agency Coordination

As mentioned earlier, PHL SS2500 specifies that the Commissioner shall, "cooperate with other state departments having jurisdiction over matters affecting the health of mothers and children, to the end that existing activities may be coordinated and duplication of effort avoided. He shall cooperate with and stimulate local agencies, public and private, in promoting such measures and undertakings as may be designed to accomplish the purposes of this section." The Department has developed strong formal and informal relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, all of which enhance the capacity of the Title V program to carry out its mission.

1) State Agencies -- Bilateral Agreements

State agencies are coordinated at the level of the Governor's cabinet. The Department of Health is a party to several written agreements or memoranda of understanding with other state agencies. These agreements serve to formalize collaborative activities between DOH and partner agencies.

The State Education Department (NYSED) is a key partner in needs assessment and priority setting for services relating to the school-aged population. NYSED and DOH have formal planning structures related to youth risk behavior surveillance, comprehensive school health, school-based primary care and dental services, and workforce and scope of practice issues. NYSED also collaborates with NYSDOH on the Supplemental Fluoride Distribution Program. The Children with Special Health Care Needs Program regularly interacts with SED's Vocational and Educational Services for Individuals with Disabilities (VESID) Program. NYSED is responsible for general supervision of all educational institutions in the State, for operating certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions, including physicians and nurses. NYSED's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services. The Youth Risk Behavior Surveillance System is administered by NYSED in collaboration with NYSDOH. We also work with the Education Department on issues such as placement of automated external defibrillators in schools, administration of fluoride rinse programs, healthcare/public health workforce matters, scope of practice issues, transition from early intervention to preschool programs, and approval of school-based primary care and dental care centers. The Department has a Memorandum of Understanding with NYSED regarding school health infrastructure and coordination. This memorandum supports the statewide implementation of comprehensive school health and wellness program. Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

The University at Albany School of Public Health is jointly sponsored by the University and our Department, which serves as the laboratory for graduate students working shoulder-to-shoulder with practicing professionals in the state health department and in local health departments. DOH and Title V staff serve as faculty and advisors to the school, and serve on the School's Continuing Education Advisory Board and on the advisory council for the North East Public Health Leadership Institute. The Bureau of Maternal and Child Health maintains a health education contract with the SUNY School of Public Health that facilitates calling upon the resources of the school for training and education of professionals, such as family planning providers, prenatal care providers, etc. Title V staff coordinate the MCH Graduate Assistant Program, under which fourteen graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement attracts bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health, enhances the Department's research capacity, and

improves the availability of pertinent and timely educational offerings for practicing public health professionals in the region. The School of Public Health sponsors the Northeast Public Health Leadership Institute (NEPHLI). Several Title V staff have attended the Institute, and several graduates serve Title V in other states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory council.

As the lead agency for the Early Intervention Program, the Department has letters of agreement with the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the State Education Department, and the Office of Alcohol and Substance Abuse Services to coordinate the implementation and operation of this program.

Department Title V staff work with the Office of Children and Family Services (OCFS) on health care of children in foster care and on issues related to the health and safety of infants and children in child care. The Early Intervention Program collaborated with OCFS in the development of a guidance document entitled, "Protocols for Children in Foster Care Who Participate in the Early Intervention Program." In 2008 the Department and OCFS entered into a partnership to expand and improve child fatality review and prevention in NYS. The partnership works to improve the collection and examination of information generated by local fatality reviews. OCFS also sponsors, with partners such as DOH, the SUNY Distance Learning Project and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction.

The State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF) Block Grant to the Department of Health for outreach and education activities to prevent unintended pregnancies and for School Health. The Department has entered into a Memorandum of Understanding with the Office of Temporary and Disability Assistance (OTDA) to provide for the transfer of these funds to the Department.

2) State Agencies -- Multi-Agency Activities
The commissioners and directors of New York State's health, education and human services agencies recognized that to improve outcomes in each of the areas for which they had responsibility, it was necessary to shift to a new paradigm characterized by prevention, early intervention and family/youth involvement. Further, to increase the effectiveness of the various systems, the agencies embarked on an effort to develop a common set of measurable goals and objectives that lead to improved outcomes for children and families. From these actions, the Council on Children and Families (CCF) and its 12 member agencies developed New York State Touchstones. Soon after, the Council became part of the national KIDS COUNT network, funded by the Annie E. Casey Foundation. Recognizing the important link between Touchstones and KIDS COUNT, the Council saw the NYS Touchstones/KIDS COUNT data books as the vehicle for highlighting the status of New York's children and families. The first data dissemination effort was the NYS Touchstones/KIDS COUNT 1998 Data Book. CCF staff soon recognized the limitations of printed documents and began developing a website to make the data directly available to stakeholders in a format that could be used for further analysis. With a grant from the State's Office for Technology, the CCF was able to contract with a vendor to do the technical development of an interactive, web-based tool that would allow data users to gather, plot and monitor New York State Touchstones/Kids Count data. The NYS Touchstones vision is that all children, youth and families will be healthy and have the knowledge, skills and resources to succeed in a dynamic society. The Touchstones framework is organized by six major life areas: economic security; physical and emotional health; education; citizenship; family; and community. Each life area has a set of goals and objectives, and a set of indicators reflecting the status of children and families.

The New York State Youth Development Team is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has lead efforts to develop and promote youth development strategies across health and human services systems in New York State. Agency team members include all major state agencies serving youth (health, mental

health, education, public assistance, juvenile justice, substance abuse, labor), as well as a wide variety of professional and public advocacy organizations. The Team's vision is for families, schools and communities partnering to promote the development of healthy, capable and caring youth. The Youth Development team, co-chaired by DOH and OCFS, has guided the creation of several cutting edge products, events and initiatives, including a resource notebook. For more details, see: http://www.health.state.ny.us/community/youth/development/ .

The comprehensive strategy of the Children's Agenda aims to provide the groundwork for healthy and successful lives for all New York's children. In 2007, New York established a Children's Cabinet chaired by the Deputy Director of State Operations. Currently, the Deputy Secretary for Education serves as the vice chair, and Cabinet Members include the commissioners and directors of 20 state agencies and several staff from the Governor's Office. To assist the Cabinet in its efforts, a Children's Cabinet Advisory Board a diverse group of experts outside New York State government was also established. Originally, the Children's Cabinet focused on enrollment of all children in the state in health insurance and implementation of the Universal Prekindergarten program. After obtaining success in each of those areas, the Children's Cabinet's efforts have now extended to addressing the needs of disconnected youth.

To respond to the federal requirement to establish or designate State Advisory Councils on Early Childhood Education and Care, the Children's Cabinet decided to reorganize its Advisory Board and establish a new body-- the Early Childhood Advisory Council (ECAC). The ECAC includes individuals with early childhood expertise who represent early care and education, health care, child welfare, and mental health programs, as well as state agencies, advocacy organizations, foundations, higher education, unions, and others involved in the provision of services to young children and their families. The Children's Cabinet's workgroups on financing and quality improvement have become a part of this new initiative. The ECAC focuses on addressing the structural issues that have impeded the development of a comprehensive system of early childhood supports and services. The Director of the Bureau of Maternal and Child Health, Dr. Rachel de Long, is an ECAC member.

From 2003 through May of 2009, the Department's Title V Program was the recipient of a federal Early Childhood Comprehensive Systems (ECCS) grant. The early years of the grant focused on cross-systems strategic planning, and resulted in a comprehensive early childhood plan. Recent years have focused on incremental implementation of the plan, with a strong emphasis on building state level cross-systems infrastructure for early childhood work. The overarching goal of the NYS ECCS plan is to support families and communities in nurturing the healthy development of children ages 0-5. The plan outlines goals, objectives and strategies within four cross-sector focus areas: Healthy Children, Strong Families, Early Learning, and Supportive Communities/ Coordinated System. A major emphasis and accomplishment in recent years has been to align the ECCS initiative with the work of the New York's Children's Cabinet, and most recently the Cabinet's Early Childhood Advisory Council. In addition, significant progress has been made by ECCS partners across a wide range of program areas, including enrollment of young children in health insurance programs, expanded mental health screening for children, parent education projects, funding for universal pre-kindergarten, significant work to coordinate and expand home visiting programs to serve at-risk families, quality improvement projects to improve developmental screening of young children with medical homes, completion and dissemination of a comprehensive data report on the health and development of children birth to five years of age, and submission of a cross-agency Project LAUNCH grant application to SAMSHA.

The Coordinated Children's Services Initiative (CCSI) is a cross-systems process for serving children with special emotional and behavioral services needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualizing planning, and encourages creative, flexible decision-making and funding strategies. CCSI Statewide Partners are: Family Representatives, Office of Mental Health, State Education Department, Office of Children and Family Services, Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Mental Retardation

and Development Disabilities, Department of Health, NYS Commission on Quality of Care and Advocate for Persons with Disabilities, and the Developmental Disabilities Planning Council. Priority areas for CCSI include the development and delivery of training and technical assistance related to building and sustaining local systems of care, including a family advocacy training curriculum. CCSI continues to work to implement the comprehensive set of recommendations for improving services for children who have cross-systems needs.

The goal of Family Support New York is to transform public/private systems and services to support and foster empowerment of families in New York State. The Council on Children and Families is the lead agency. Other members include the Department of State, the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Family Development Association of New York State, Family Support NYS, and various community and parent representatives.

The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly Third Thursday Breakfast Broadcasts (T2B2). T2B2 provides statewide continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available.

3) Local Health Departments
County and city (NYCDOH&MH) health departments play an essential role in the assurance of high-quality, accessible maternal and child health services. They assess the needs of their local communities, work with their communities to design and implement programs that meet those needs, and evaluate the effects of those programs on their communities. Under Article 6 of the New York State Public Health Law, local health departments extend the powers of the state health commissioner. Under Article 6, local health departments perform comprehensive community health assessments, and subsequently produce a Municipal Public Health Service Plans and Community Health Assessments. Plans address the needs of the maternal and child health population in health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. Working with the Title V staff provide technical assistance to local health units in plan development, participate in the review process and monitor implementation of the plans. Because local health departments know local systems and community needs, plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health units play a critical role in fostering local collaborations and locally addressing disparities in health outcomes.

4) Provider and Academic Communities
Numerous private not-for-profit groups and educational institutions are consulted and enlisted in planning, developing, providing and evaluating maternal and child health services in New York State.

First, the Department provides the bulk of its services through contracts with community-based providers, including hospitals, diagnostic and treatment centers, community-based organizations, colleges and universities. These contracts are specific about the services to be provided and the outcomes expected. All of the nearly 750 contracts maintained by the Division of Family Health to perform Title V and related services represent collaborations to provide high quality services to the people of the state, and the commitment of those contractors is extraordinary. The interactions of the Department with our service providers represent collaborative relationships of the highest order on behalf of health of our maternal and child population.

The Family Champions Project engages parents of children with special health care needs in

training on planning, policy and advocacy. Family Champions assisted Title V by participating in consumer focus groups and testifying before the Maternal and Child Health Services Block Grant Advisory Council. Family Champions will continue to be engaged in program planning and policy development initiatives with the Children with Special Health Care Needs Program.

New York State also partners closely with the American College of Obstetricians and Gynecologists, District II, on a number of maternal initiatives, including the Maternal Mortality/Safe Motherhood initiative, which attempts to identify each maternal death in New York State and use reviews of these deaths to help inform policy decisions, in conjunction with the Department of Health. In addition, this collaboration leads to training initiatives that are implemented across the state to improve the hospital-based and prenatal care of pregnant women.

New York State has a long-established system of highly specialized Regional Perinatal Centers (RPCs), described in Section III B. Starting in 2009, RPCs began a collaborative initiative with the department and the National Initiative for Children's Healthcare Quality (NICHQ) to implement several learning collaborative projects to improve newborn and maternal outcomes, reduce health care costs and establishes the state's capability for ongoing quality improvement/transformation in heath care.

Many federal Healthy Start grantees are also grantees of New York State Department of Health under the Comprehensive Prenatal/Perinatal Services Network initiative. While the Networks, initially funded under Title V, have moved onto a different source of funding, the need for coordination with Title V programs continues. The Department holds at least two meetings per year with Healthy Start grantees to foster better communication and explore areas for potential collaboration.

The Comprehensive Prenatal/Perinatal Services Networks collectively have formed the Association of Perinatal Networks (APN) that meets regularly with the Department of Health. .

Area Health Education Centers (AHECs) work to recruit, retain, and support health professionals to practice in communities with health provider shortages, developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, and providing continuing education and professional support for professionals in these communities. They encourage local youth to pursue careers in health care. The MCH Advisory Council, the State Health Department and the AHECs are mutually concerned about the aging of the health care workforce; the aging of nursing and dental faculty; current and future shortages in certain key health professions; and in interesting young people in health careers early in their student careers. The Bureau of Dental Health is working with AHECs and local rural health networks to improve access to primary dental care in rural areas.

The Bureau of Dental Health held a series of regional oral health stakeholder meetings involving school dental health and Head Start/Early Head Start stakeholders for the purpose of needs assessment and discussing implementation of the statewide Oral Health Plan. Attendees received meeting summaries, membership in the Oral Health listserv, information about additional potential regional and statewide partnerships, and an invitation to participate in the newly formed statewide Oral Health Coalition. The Dental Bureau also engaged an expert panel to consider the scientific evidence related to oral care during pregnancy and in early childhood and this panel participated in formulating practice guidelines for New York State dentists and obstetrical care providers. The guidelines have been distributed, and are available on the NYSDOH website at http://www.health.state.ny.us/prevention/dental/

The Department also maintains a relationship with the Columbia University School of Public Health through a Collaborative Studies Initiative. Metropolitan Area Regional Office staff serve as advisors and contract managers to the program. Columbia students and public health faculty identify current issues in maternal and child health, and apply public health theory and practice in

designing and implementing solutions to those issues.

Title V and the Adolescent Coordinator maintain linkages to the Leadership Education in Adolescent Health (LEAH) Program at the University of Rochester. The purpose of LEAH is to prepare trainees in a variety of professional disciplines for leadership roles in the public and academic sectors and to ensure high levels of clinical competence in the area of adolescent health. Training is given in the biological, developmental, emotional, social, economic and environmental sciences within a population-based public health framework.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicators assist New York State in tracking trends in significant maternal and child health status and measuring progress in achieving specific goals. These indicators also provide an opportunity to benchmark New York's progress against other similar states and make informed decisions regarding investments in health systems and services. Extensive data systems and analyses, well beyond the Health Systems Capacity Indicators, are used by New York State, municipalities and other health and human service providers to better ensure the needs of the maternal and child health population are met. Much of these data are posted on the public web site broken down by different variables for easy access, while other more specific data are posted on secure sites for access by municipalities and hospitals for use in program and service planning and evaluation.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	57.9	62.0	46.5	58.1	58.1
Numerator	7236	7567	5569	7022	7022
Denominator	1249101	1220468	1196688	1208495	1208495
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

2008 data are being used as a proxy for 2009.

Notes - 2008

2008 data updated and finalized

Narrative:

Notes - 2011

2008 data updated and finalized; 2008 data used as proxy for 2009; 2009 data to be finalized in late 2010.

Over the past ten years, the rate of children hospitalized for asthma fluctuated, but represents an overall decline from the 2000 rate of 62.9 per 10,000 children to the current rate of 58.1. Rates

continued to be higher in New York City, compared to the rest of the State.

In 2006, NYS DOH published a Summary Report from the National Asthma Survey. The National Asthma Survey is a random digit dialing telephone survey that screened for presence of asthma by household. Overall 31,090 individuals from 11,713 household were screened, with 1,970 detailed interviews completed.

About 467,000 children, birth to age 17 (10.6%) of the NYS child population have been told by a health professional that they ever had asthma and about 368,000 (8.4%) had current diagnosed asthma. For children birth to age 4, the rate was 6.7%, for 5- to 9-year-olds, 9.4%, for 10- to 14-year-olds, 8.8%, and for 15- to 17-year-olds, 8.3%. For adults, the 18- to 24-year-old age group had the highest current asthma prevalence at 9.8%. Current asthma prevalence is significantly higher in male children (9.8%) compared to female children (6.8%), but prevalence in adult females (9.0%) is higher than in adult males (6.0%). Black children had the highest prevalence at 10.0%, compared to White (7.2%) and Asian children (4.3%). Black adults had higher rates (8.3%) than White (6.6%) and Asian (1.8%) adults. Hispanics had higher current asthma prevalence than non-Hispanic children (10.9% vs. 7.4%) and adults (9.0% vs. 6.3%). New York City children had a higher prevalence than children in the rest of the State (9.7% vs 7.4%), and New York City adults had lower rates than adults in the rest of the state (7.1% vs. 8.0%).

Children and adults living below the Federal Poverty Level (FPL) had higher current asthma prevalence than those above the FPL. For children the prevalence rates were 10.1% for those below FPL vs. 8.7% for those above; for adults rates were 9.2% for those below FPL vs. 7.2% for those above.

Children aged 0-4 years had the highest emergency department (ED) visit rate (181.4/10,000). The asthma ED visit rate decreased in older age groups. During 1996-2005, the 0-4 year age group had the highest hospital discharge rate.

"Use of Appropriate Asthma Medications" is a performance measure in QARR reported annually. NY is at 94% for commercial and Child Health Plus plan performance and 90% for Medicaid plan performance. QARR data shows that 95% of commercial, 94% of Child Health Plus and 92% of Medicaid plans achieved this goal.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	76.9	72.7	72.7	77.6	76.3
Numerator	111874	108995	108995	117580	116490
Denominator	145432	149958	149958	151439	152710
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data are for children enrolled in both Medicaid Fee-for-service and Medicaid Managed Care. Data for 2008 has been finalized.

Notes - 2007

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Narrative:
Medicaid rates for children's health measures generally have steadily increased over time and often surpass national average rates. Data above are for children enrolled in Medicaid Fee-For-Service and Medicaid Managed Care, and reflect steady capacity in this area over the last several years, with some year-to-year variation.

A related measure is collected for Medicaid Managed Care (MMC) Plans through the state's Quality Assurance Reporting Requirements (QARR). For 2007, 98% of the children continuously enrolled in MMC had at least one well child visit between birth and 15 months, and 79% had five or more well child visits by 15 months. These rates were above the 2003 measurement year of 96% and 78% respectively, however, the methodology differences between these two years make the results not comparable. The majority of infants enrolled in Medicaid in New York State are served through managed care rather than fee-for-service.

Improving the quality and frequency of preventive care for children is a priority of the state's Medicaid and Title V programs and for Medicaid managed care plans in NYS. Plans' quality improvement efforts address barriers including: delays in processing newborn Medicaid identification numbers; lack of provider reminder systems; non-standardized medical record documentation; and lack of member/parent understanding of the importance of well child visits. Health plans educate members and providers through newsletters and reminder mailings, annual 'birthday cards' as reminders to members and physician profiling to identify members who are due for a preventive visit. Health plans have encouraged their providers to use standardized forms to document well child visits, conduct on-site visits to review records for compliance, and some plans have offered providers financial incentives to improve their well child visit rates. Case management for high risk newborns is offered by plans to assist in the assessment of newborn needs, develop care plans and assist the member to obtain care including well child visits in the first 15 months.

Title V staff monitor access to programs and services on a local level and work with the DOH Office of Health Insurance Programs to identify and solve access issues. The DOH's public health home visiting services provide community outreach and direct services to high-risk women and families. These programs promote well baby care visits, assisting women with keeping these visits after the baby is born. The Community Health Worker Program and the Nurse Family Partnership program ensure new mothers have a well baby visit within 4 wks of delivery. Healthy Mom - Healthy Baby Prenatal and Postpartum Home Visiting program will perform birth certificate reviews to identify high-risk women, and outreach to engage high-risk women in home visiting services and keep their well baby appointments. (Refer to HSCI 04 for further detail.)

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	84	84	99	99	99
Numerator					
Denominator					
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2007 data are being used as a proxy for 2009. Data are for the percent of children aged 15 months who recieved 1 well child or preventive visit is used. Since 1999 measures have been calculated using a data source in which the percentage is weighted by plan enrollment. Since the rate is a weighted rate the numerator and denominator are not available.

Notes - 2008
2007 data are being used as a proxy for 2008. Data are for the percent of children aged 15 months who recieved 1 well child visit.

Notes - 2007
Data are for the percent of children aged 15 months who recieved 1+ well child visits

Narrative:
Child Health Plus, New York State's State Child Health Insurance Plan, is exclusively a managed care product. Data on provision of well child visits for children aged 15 months is reported by plans through the state's Quality Assurance Reporting Requirements (QARR). For children continuously enrolled in Child Health Plus plans, the percent of children with at least one well child visit by age 15 months rose from 98% in 2003 to 99% in 2007. A more meaningful measure of capacity and performance used for QARR is a subset of this group, the percent of children with five or more well child visits in the first 15 months, which increased from 79% in 2003 to 88% in 2007 (Data not shown).

Improving the quality and frequency of preventive care for children is a priority of the state's Child Health Plus and Title V programs and for Child Health Plus managed care plans in NYS. As noted for HSCI 02, plans' quality improvement efforts have addressed numerous barriers to timely provision of well child care. Community-based public health programs that target high-need communities and families, described above for HSCI 02 and below in HSCI 04, promote and facilitate utilization of primary and preventive health care for babies in families receiving services.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	66.5	65.9	63.5	65.5	65.5
Numerator	130854	131416	126795	124528	124528
Denominator	196825	199342	199659	190222	190222
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Narrative:
Notes - 2011
2008 data has been finalized since previous submision. 2009 data to be finalized in late 2010.

This data has remained relatively consistent over time. Provisional data from 2009 show that 65.5 percent of pregnant women achieved the Kotelchuk Index objective, and the indicator held steady when compared with the rate from the previous year. Racial, ethnic and regional disparities continue to be reflected. The index was 69 percent for Whites compared with 52.7 percent and 57.8 percent for Blacks and Hispanics, respectively. Regionally, 69 percent of pregnant women in the Rest of State and 61.7 percent in NYC achieved the target.

NY has undertaken major efforts to improve access to prenatal care. The Office of Health Insurance Programs, in collaboration with the DFH, revamped NY's Prenatal Care Assistance Program (PCAP), which provided prenatal care to women up to 200% FPL. Chapter 53-Laws of 2008 established Medicaid (MA) payment methodology based on Ambulatory Patient Groups (APG), for Medicaid services in outpatient clinics, ambulatory surgery, emergency departments. The legislation also required the Dept to update standards for prenatal care and eliminated the PCAP program, requiring all providers to comply with standards that incorporate evidence-based procedures and integrate standards from ACOG and AAP, and reflect expert consensus regarding care. All MA enrolled Article 28 prenatal care providers perform presumptive eligibility determinations, and assist with completion of the full MA application and managed care plan selection, allowing women to immediately receive care while awaiting full Medicaid determination.

The Dept also oversees programs to improve early and continuous prenatal care including the Comprehensive Prenatal-Perinatal Services Networks, community-based organizations whose mission is to organize the service system at the local level. The Community Health Worker Program provides outreach and home visiting services to pregnant women who are at highest risk for poor birth outcomes. In 2009, Healthy Mom-Healthy Baby was implemented in LHDs serving six highest need counties of the state. Programs receive funds to develop a systems approach to perinatal health, including early identification of women not engaged in prenatal care, identification of risk factors, coordination of home visiting services and referrals. The 2009 State budget also appropriated $5 million under TANF for the Nurse Family Partnership (NFP) program to improve outcomes for first time mothers. The three certified NFPs in NYS have been funded based on number of TANF eligible women to be served.

Public awareness materials are available to promote early entry into prenatal care. A media campaign encouraging women to access prenatal services is being implemented in areas with the highest rates of adverse perinatal outcomes through May and June, 2010, instructing women to call the 24/7 Growing Up Healthy Hotline for information.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	94.6	94.4	94.4	90.0	90.7
Numerator	1966625	1909170	1909170	1805488	1876851
Denominator	2079460	2021928	2021928	2006098	2068245
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

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Narrative:

This indicator offers a crude approximation of the extent of health care utilization by the population of children eligible for Medicaid in New York State. It tells us that a large proportion of Medicaid-eligible children access at least one Medicaid-paid service of any kind each year, and that the proportion has remained constant over the past three years. What it does not tell us are the reasons why children obtained services, nor whether there are major disparities in utilization of Medicaid services. The indicator is also silent on the breadth, quantity, and quality of services rendered to those children. Of limited utility within New York State, this indicator is not useful for interstate comparison purposes, given the wide differences in Medicaid eligibility requirements and service environments that exist across the country, and might well be dropped in favor of more valid indicators of Medicaid service utilization.

That said, New York State makes considerable effort to help ensure that eligible children are enrolled in Medicaid, and once enrolled, that they access health services -- especially preventive and primary care services -- in a manner that contributes to their health and well-being. To help gauge the extent of health insurance coverage and related utilization of health care, the Department relies on two major information resources. The first is the DOH report entitled, Profile of the Uninsured in New York State in 2008. This profile is based on data from the US Census Bureau's 2008 Annual Social and Economic Supplement to the Current Population Survey (CPS), and provides estimates for all NYS counties. Some highlights of the report include:

- In 2008, 7.4% of the state's population under 19 was uninsured, about 343,000 children, a sharp decline from 2007 estimates of 9.2% and 434,481, respectively;
- The 2008 rate is below the comparable value for the nation at large, which was 10.3% for children under 19;
- The uninsured rate for children in NYS was notably lower in 2008 than five years earlier, and the drop in 2008 reversed three consecutive annual increases, testament to the extraordinary efforts NYS has made to improve public insurance enrollment in recent years.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	38.9	44.3	46.4	46.4	46.9
Numerator	144365	159486	166217	166217	174324
Denominator	370657	360268	358116	358116	371495
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

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Narrative:
The percentage of EPSDT-eligible children 6 - 9 years of age receiving dental services has increased each year since 2003. However, despite improvements in the provision of dental services to low income children, NYS remains below the HP 2010 target of 56%.

A 2007 Department study identified several barriers to care. The most common barriers cited were: afraid or nervous to go (15%), dentists called do not accept their insurance (14%), do not like dentists or their particular dentist (13%); it is difficult to schedule an appointment (12%), have to wait too long in the waiting room (11%), and have trouble getting transportation (9%). In 2008, only 34% of all practicing dentists participated in the Medicaid program.

Strategies for improving access to dental care are addressed in the NYS Oral Health Plan and by the Oral Health Coalition's (NYSOHC) Access to Care Sub-Committee. The NYSOHC is comprised of individuals representing themselves and individuals representing institutions, agencies, or organizations who share a common interest in oral health and access to care. The Sub-Committee meets regularly to implement sections of the plan relating to access to oral health care. Strategies for improving access to dental care are addressed in the plan and by the NYSOHC's Sub-Committee.

To assess the availability of dentists, the BDH in collaboration with the Primary Care Office and the American Dental Association, is developing a Children's Oral Health Atlas. It will facilitate the identification of Dental Health Professional Shortage areas. The BDH funds 31 projects in high need underserved areas for preventive oral health services focused on maternal and child health populations. The majority of projects provide preventive dental services to children through school-based and school-linked dental programs and ensures more children have a dental home and access to comprehensive dental treatment programs. A HRSA supported grant focuses on increasing access to, and utilization of, dental services by children. Currently 42 school-based programs provide oral health services to children at 625 schools across the State.
Several statewide initiatives were recently implemented to ensure that children have opportunities and resources needed to achieve and maintain optimal oral health. The Prevention Agenda includes decreasing dental caries disease among third grade children as a public health priority. To increase access to oral health care for children and identify at risk children in need of treatment services, a dental health certificate is requested for school children entering kindergarten and grades 2, 4, 7, and 10. The State Medicaid Program approved quarterly applications of fluoride varnish by dental and child health care professionals for children under seven years of age that should result in more low income infants and children receiving oral health services and timely identification and treatment of early signs of dental caries disease.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	100.0	100.0	0	0	0
Numerator	1	1			

Denominator	1	1			
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program. In 2008, 2 percent of children enrolled in the CSHCN Program had SSI

Notes - 2008
All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program. In 2008, 2 percent of children enrolled in the CSHCN Program had SSI.

Notes - 2007
All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program.

Narrative:
Notes - 2011 - This measure is not applicable to New York State as all SSI beneficiaries are categorically eligible for Medicaid, which is a more generous health care insurance package than the Physically Handicapped Children's Program, a gap-filling program for CSHCN. In 2008, 2% of the children receiving care coordination and referral services through the CSHCN Program had SSI.

Children with special health care needs who have severe, handicapping conditions and who contact the CSHCN Program are referred to SSI. In 2009, 267 children were referred to SSI and 211 of those children successfully obtained SSI (79%). The assessment and referral activity of the CSHCN Program is significant as it demonstrates that staff recognizes the benefit SSI can provide families and accurately refer those children most likely to be determined eligible for SSI. SSI provides income to help families obtain needed services to care for their disabled child. The CSHCN Program will continue to fund and provide technical support to local CSHCN Program contracts that support staff to perform information and referral activities.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	8.6	7.8	8.2

Narrative:
Notes 2011
2008 data has been finalized since last submission. 2009 data to be finalized in late 2010.

The percent of LBW has decreased slightly from 2006 for the entire NYS population (8.3) and also decreased in the Non-Medicaid population (8.2) but the rate has remained consistent at 8.6 for the Medicaid population. A focus of DOH's efforts to reduce low birth weight is a systems-wide effort to improve early entry into comprehensive prenatal care and support and services offered through the Dept's perinatal and home visiting programs.

NYS has a well-organized system of regionalized perinatal care that ensures that appropriate hospital care is provided to women and their newborns. A system of regionalized perinatal services includes a hierarchy of three levels of perinatal care provided by the hospitals within a region and led by a regional perinatal center (RPC). Women at highest risk for poor birth outcomes are referred to RPCs and supportive health and social services. Research strongly supports regionalization as a means of improving maternal and infant outcomes.

The extension of Medicaid prenatal care and the requirement that all Article 28 hospitals/ diagnostic and treatment centers that offer prenatal care provide Presumptive Eligibility to pregnant women expand access to prenatal care and Medicaid coverage. NY also passed legislation in 2009 allowing nurse practitioners to bill MA in all specialties, and licensed clinical social workers will be reimbursed for services to children, adolescents and pregnant women, thereby expanding access to health and supportive services.

The health of the woman prior to pregnancy significantly impacts birth outcomes. A preconception care (PC)packet, including PC checklist and PC Guide for Optimizing Pregnancy Outcomes, was developed in collaboration with the ACOG-NY, and distributed to over 16,000 obstetricians/gynecologists, nurse practitioners, and pediatricians. The materials are designed to encourage medical professionals to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes. The Dept also funded development of the Preconception Health Café, a web-based course to about the importance of preconception health and provide tips to maximize opportunities to discuss preconception health with women.

Title V staff participate in interagency projects to address specific perinatal issues. A Fetal Alcohol Spectrum Disorder Interagency Workgroup promotes coordination among State agencies to design and support a comprehensive system of care to eliminate alcohol use during pregnancy and improve the lives of New Yorkers affected by prenatal alcohol exposure. Representatives include: Council on Children and Families, Office of Children and Family Services, Office of Mental Retardation/ Developmental Disabilities, Office of Alcoholism and Substance Abuse Services, and DOH.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	7.4	5.1	5.8

Notes - 2011
Medicaid and non-Medicaid infant death rates are based on infant deaths among residents of NYS excluding NYC.

Narrative:
Notes - 2011
Includes Upstate data only, New York City data is unavailable.

State capacity to reduce infant mortality includes a number of surveillance, community-based and clinical activities, services and supports.

Early access to high quality, comprehensive prenatal care remains a cornerstone of promoting infant well being. Analysis of state vital statistics data indicate that conditions originating in the prenatal period and congenital malformations account for 74% of all infant deaths. Major elements of New York State's system include: Medicaid standards and reimbursement for prenatal care; community-based home visiting programs including Community Health Worker, Nurse Family Partnership and Healthy Mom-Healthy Baby; consumer outreach and education through media campaigns and the Growing Up Healthy Hotline. See HSCI 04 for summary of capacity to support access to comprehensive prenatal care and other supports and services. In addition, preconception health is increasingly emphasized across public health activities, including perinatal, family planning, adolescent health and other programs as a critical time period for impacting both maternal and infant health outcomes.

Within the Title V Program, there are specific projects to monitor and analyze infant mortality data to guide the development of priorities and interventions. Based on 2007 vital statistics data, the top five causes of infant death accounted for 83% of all infant deaths. Following conditions originating in the prenatal period and congenital malformations, SIDS and accidents account for 8% of infant deaths, and diseases of the heart account for another 1 %. Based on an 11-year report on child deaths, communicable and chronic disease and unknown causes account for much of the remaining 17% of deaths. Driven by these data, in addition to the prenatal activities described above, efforts to reduce infant mortality have focused on promotion of safe sleep and reduction of SIDS, including extensive risk reduction education for SIDS and other sleep related deaths, and work with local child fatality review and data collection activities to better understand the contributing factors to sleep related, other accidental deaths and homicides. In addition, the Title V program collaborates with other partner programs including WIC, Injury Prevention, Healthy Families New York (a home visiting programs administered by the state Office of Children and Family Services focused on the prevention of child abuse) and others to address factors that contribute to infant mortality.

A specific project is in progress to assess "Perinatal Periods of Risk" statewide and by county. Preliminary multi-year analysis of infant mortality data for New York State (excluding New York City) has identified young maternal age, black race and lower educational attainment as risk factors for infant mortality. These findings will further inform ongoing program development in this area.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in	2008	payment source from birth certificate	60.4	81.9	72.3

the first trimester					

Narrative:
Notes - 2011
Denominator excludes births with unknown date when prenantal care began.

Capacity in this area is closely related to that described for HSCI #04. Medicaid populations generally fare less favorably than privately insured populations for this and other perinatal health measures. Medicaid prenatal care increases access for high risk women to high-quality prenatal care that includes standardized risk assessment, medical and supportive services. Establishing consistent standards in the Medicaid prenatal care program and requiring all prenatal care providers that provide prenatal care to the Medicaid population to provide care in conformance to these standards will increase access to high quality, comprehensive prenatal care.

A variety of public health strategies engage high risk pregnant women in early prenatal care. These include: Community Health Worker Program, Nurse Family Partnership for high risk first-time mothers early in pregnancy, and Healthy Mom -- Healthy Baby Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services. The Title V program collaborates with state Office of Children and Family Services for their Healthy Families New York home visiting program. All programs are targeted to communities with highest needs. The statewide Growing Up Healthy Hotline links women to needed services, with periodic public awareness media campaigns to direct women to the hotline.

A re-design of the state's Medicaid reimbursement system in 2008 ensures that Medicaid reimbursement will promote the highest standards of evidence-based care. This should enhance the availability of high quality prenatal care to women statewide. See HSCI #04 for details.

The Department will continue to promote early entry to prenatal care through outreach and case finding strategies to identify high risk women early and ensure engagement in comprehensive, quality prenatal care.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	54.7	73.4	65.5

Narrative:
Capacity in this area is closely related to HSCI#04 and #05C. Medicaid populations generally fare less favorably than privately insured populations in this and other perinatal health measures.

New York's commitment to ensuring the availability and accessibility of comprehensive prenatal

care through the Medicaid prenatal care program increases access to high-quality prenatal care for high-risk, hard-to-reach women. Providers enroll women and sustain utilization of care. Standardized risk assessment helps identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services. Parallel reforms of the state's Medicaid reimbursement system to an APG-based payment structure is designed to aid improvements in the delivery of prenatal care in NYS.

A variety of strategies are used to enhance outreach to engage high risk pregnant women in early prenatal care and support ongoing utilization of recommended care and supportive services throughout pregnancy. These include home visiting programs such as the Community Health Worker Program, the Nurse Family Partnership, which engages high risk first-time mothers early in pregnancy, and the Healthy Mom -- Healthy Baby Prenatal and Postpartum Home Visiting Program, designed to establish a county system of perinatal health services, with a strong focus on outreach to engage pregnant women in early prenatal care. These programs are targeted to specific communities with highest needs. The statewide Growing Up Healthy Hotline links women to needed services, with periodic outreach media campaigns.

Public health programs that serve at-risk adolescents - including School-Based Health Centers (SBHC), Family Planning and Reproductive Healthcare providers and community-based adolescent pregnancy prevention programs - include provisions for preventive health services, pregnancy prevention, and, when needed, prompt referral of pregnant teens to prenatal care. Within the SBHC program, SBHC staff may provide prenatal care services directly, coordinate services with another provider or refer pregnant students for appropriate prenatal care, with follow-up to ensure that there is continuity of care. Where indicated, referrals are made for additional supportive health and social services.

The Department will continue to promote access to early, continuous and comprehensive quality prenatal care services through outreach to identify and engage high-risk women, implementation of comprehensive standards and reimbursement for promotion of Medicaid prenatal care services, and steps to enroll Medicaid-eligible pregnant women in managed care plans as early as possible to assure optimal management of prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
The Office of Health Insurance Programs (OHIP) administers the Medicaid (MA) and Child Health Plus (CHP) programs. Access to insurance is imperative for improved health outcomes, to mitigate racial and ethnic disparities and, is a priority of NYS. Infants to age one and whose family incomes are at or below 200% of the FPL are eligible for MA. Those infants born to women covered by MA are eligible for coverage to the end of the month of their first birthday. Infants with family incomes up to 400% of the FPL are eligible for health insurance coverage under CHP, New York's SCHIP program.

To receive coverage, eligible families must enroll in a health plan. Coverage for those under 160% FPL is free. The premium for families between 160 - 222% is $9 per child per month, with a maximum of $27 per family per month. Families with incomes between 222 - 250% FPL, contribute $15 per child per month, with a maximum of $45 per family. Families with incomes between 250 - 300% FPL contribute $30 per child per month, with a maximum of $90 per family. Families with incomes between 300 - 350% FPL contribute $45 per child per month, with a maximum of $135 per family. Families with incomes between 350 - 400% FPL contribute $60 per child per month, with a maximum of $180 per family. At incomes above 400% of the FPL, CHP is available at full premium. There are no co-payments for services.

Over the past several years, NY has implemented initiatives to increase access and enrollment. For example, authorized medical providers and community-based organizations provide application assistance as "Facilitated Enrollers (FEs)." FEs are able to determine a child presumptively eligible for MA or CHP for a limited time if they appear eligible for coverage based upon uniform criteria. In June 2009, NY received federal approval to waive the six-month waiting period for families with a child under five, or any child whose family must contribute more than 5 percent of their income to purchase insurance. Effective April 1, 2010, applicants for MA and CHP are no longer required to have a face to face interview and can mail an application and receive a determination.

NYS is one of eight states participating in a program funded by the Robert Wood Johnson Foundation to increase enrollment and retention of children eligible for MA and SCHIP but are not enrolled. The program, "Maximizing Enrollment for Kids" seeks to help states improve systems, policies and procedures to increase the proportion of eligible children enrolled and retained in MA and SCHIP. New York will explore the potential of enrolling more children by simplifying the enrollment process and using publicly available screening tools to make it easier for families to apply for coverage. NY will be partnering with community-based organizations, faith groups and health and human service providers for a "Connections to Coverage" campaign to link uninsured children to facilitated enrollment in their communities.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	 400

Narrative:
The Office of Health Insurance Programs (OHIP) administers the Medicaid (MA) and Child Health Plus (CHP) programs within the Department. Access to insurance coverage for all New Yorkers is a priority of the State. Children one through five are eligible for Medicaid at 133% of FPL.

Children ages six to nineteen are eligible at 100% of the FPL.

Children with family incomes up to 400% of the Federal Poverty Level are eligible for health insurance coverage under Child Health Plus, New York's SCHIP program. Refer to HSCI #06A for further details regarding strategies to increase enrollment and retention.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Narrative:
Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level (FPL) are eligible for Medicaid. Pregnant women with income of less than 100% FPL are eligible for the full array of ambulatory Medicaid services including, but not limited to, primary care, dental health and eye care as well as other supports and services offered to the Medicaid population. Those with incomes above 100% FPL but less than, or equal to 200% FPL are eligible for coverage for Medicaid Prenatal Care only.

In 1996, Medicaid managed care legislation expanded Medicaid benefits for 26 months after the end of a pregnancy to women under 185 percent of the federal poverty level who had previously been on Medicaid while pregnant (the poverty level was expanded to 200 percent in 2000). This program is known as the Family Planning Extension Program (FPEP). The federal government also approved the state's Medicaid waiver to expand family planning services for more than 800,000 New Yorkers, and on October 1, 2002, the Family Planning Benefit Program (FPBP) was implemented. The FPBP increases Medicaid coverage for family planning services for individuals up to 200 percent of the federal poverty level, regardless of previous Medicaid eligibility or pregnancy.

Pending approval from the Federal government, income limits for Medicaid eligibility will be increased. Women with incomes up to 120% FPL will be eligible for full Medicaid services. Women with incomes above 120% FPL and up to and including 230% FPL will be eligible for prenatal care services under Medicaid.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant	3	Yes

birth and infant death certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
In addition to data matching and survey activities, several DOH initiatives have data capacity expansion projects planned or in process.

- The State Systems Development Initiative, (SSDI) supports the Child Health Information Integration Project (CHI²) that will provide a framework that enables DOH to integrate systems containing child specific data, facilitating data sharing and exchange with EMRs and RHIOs that DOH supports via the HEAL-NY grants and enabling sharing of child data cross public and private sectors consistent with PHL. CHI² aims to develop an integrated data system to improve quality of care, reduce medical errors, collect individual data for activities such as Newborn Hearing Screening, provide seamless flow of information between jurisdictions, link events of public health significance in a child's life and enable bi-directional data sharing. The initial data systems that CHI² will focus on are Statewide Perinatal Data System, Newborn Hearing Screening, Neonatal Intensive Care Unit Module, Newborn Bloodspot Screening, Immunization (NYSIIS), New York Early Intervention (NYEIS) and Lead (Lead WEB).
- DOH is undertaking a multi-phase project to link NYSIIS with the statewide childhood blood lead registry (LeadWeb) to improve lead testing and reporting. When fully implemented, this system will prompt and reinforce lead testing of patients as part of routine well child care, and provide a tool for DOH and LHDs to systematically identify children who have not been tested for lead to target qi and compliance activities.
- DOH collaborated with the Public Health Informatics Institute to develop the Business Case Model (BCM), which provides a detailed picture of the costs and benefits of integrating child health information systems.
- The Bureau of Dental Health (BDH) partners with PRAMS and produced reports that were the basis of oral health guidelines for the care of pregnant women and young children, and is also working on a report on the status of fluoride varnish application in NY. BDH works closely with Medicaid on producing county and age-specific data on the use of dental services by the

maternal child health population. The data are being used to identify areas with the greatest need for services and to recommend changes to Medicaid to address these needs.

- BDH has partnered with OHIP to obtain data on claims, expenditures and number of providers participating in Medicaid. These data are being utilized to assess the impact of fluoridation and availability of dentists to treat children.
- The CSHCN Program will improve quality of data reported to the NYSDOH and provide local programs with the capability to run reports on their data, allowing use of data for local service systems improvements.
- The Bureau of Maternal and Child Health is collecting information on each baby admitted to a NICU in New York State. Plans are underway to link this data set to birth certificates, hospital discharge data, and death certificates.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
NYS Youth Tobacco Survey	3	Yes

Notes - 2011

Narrative:
New York participates in the Youth Risk Behavior Survey (YRBS) through the New York State Education Department (NYSED). In addition to YRBS, data are available from other sources. NYSED publishes the survey data on their website.

NYSED also participates in the School Health Profiles. The School Health Profiles is conducted by NYSED with middle and high school principals and lead health education teachers to assess school health policies and practices in states, large urban school districts, territories, and tribal governments. Tobacco use prevention education and policies pertaining to tobacco and other health related topics are included. The profile information is available to the NYS Department of Health upon request.

Adolescent smoking rates are available to the New York State Department of Heath through both the YRBS and through the Youth Tobacco Survey. The Division of Chronic Disease Prevention and Adult Health employs an epidemiologist for the tobacco program who works with both adult and child smoking data. These data analyses are readily accessible to the Title V programs and the Public Health Information Group.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section profiles New York's maternal and child health priorities, selected performance measures and program activities and discusses the extent to which National and State objectives were met in the program year. Summaries have been included at the beginning of each section to provide an overview of general state progress on measures.

As previously described in the Needs Assessment section, New York' s priority setting process included a review of the needs of the MCH populations, an examination of existing program priorities and realignment of the priorities to address new identified needs to the extent that resource permit. Performance related to program priorities was assessed to ensure MCH programming results in real improvement in the health and well being of the MCH populations in New York State.

A brief summary of New York's accomplishments through the use of Title V and other funds appears in Section B. New York's progress on Federal and State Performance Measures and Outcome Measures are tracked on Forms 11 and 12.

B. State Priorities

The relationship between the priority needs, the National and/or State Performance measures was extensively discussed in Section 5 of the needs assessment. The State Performance measures, as well as the relevant national health system capacity indicators, Performance Measures, Outcome Measures and Health Status Indicators were also related to State priorities in Section V. The state capacity and resource capability to address these priorities was also extensively discussed in Section 3 of the needs assessment. As discussed previously, stakeholder perceptions of state priorities for the MCHBG five year needs were very aligned with priorities identified by the Department. The Department has already begun significant efforts to address these priorities as described in the Needs Assessment.

The Department is very committed to reducing health disparities. This commitment is reflected in the priorities for the new MCHBG grant cycle. Although health disparities have narrowed in several MCH performance areas, health disparities at unacceptable levels continue to persist. These disparities may be caused by a number of factors, including socioeconomic and environmental factors, barriers related to access and quality of care, differences in health literacy, immigration status, linguistic and cultural differences which create barriers to access to health care, health literacy, as well as a variety of other factors.

Addressing these disparities must begin with data analysis at finer level of stratification, a process which is currently underway in the Department. Program services are increasingly targeted to communities with health disparities and poor outcomes. Programs must be representative of the communities they serve, both in terms of board members and staff that provide services. Existing programs are evaluated and modified if they are ineffective in addressing issues of health disparities.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100

Annual Indicator	100.0	100.0	77.2	76.0	76.0
Numerator	246243	252014	3542	3238	3238
Denominator	246243	252014	4586	4263	4263
Data Source				Newborn Screening Program data set	Newborn Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
2008 data are being used as a proxy for 2009.
Unlike in 2002 through 2006, the numerator and denominator numbers in 2007 and 2008 represent only the infants screened positive, rather than all infants screened.

Notes - 2008
Unlike in 2002 through 2006, the numerator and denominator numbers in 2007 and 2008 represent only the infants screened positive, rather than all infants screened.

Notes - 2007
Unlike in 2002 through 2006, the numerator and denominator numbers in 2007 and 2008 represent only the infants screened positive, rather than all infants screened.

a. Last Year's Accomplishments
-249,271 infants were screened in 2009 for all 45 conditions, which include the 29 core conditions and most of the secondary conditions plus HIV and Krabbe disease, both of which are unique to NYS. Screening is performed by Wadsworth Center's Newborn Screening Program at the NYSDOH.
-All newborns with a specimen submitted are tested for all 45 congenital conditions on bloodspots, including:
- Congenital adrenal hyperplasia (CAH)
- Congenital hypothyroidism (CH)
- Sickle cell disease and other hemoglobinopathies
- Exposure to HIV-1
- Homocystinuria
- Hypermethioninemia
- Maple syrup urine disease
- Phenylketonuria
- Tyrosinemia, types 1, 2, and 3
- Carnitine-acylcarnitine translocase deficiency
- Carnitine palmitoyltransferase deficiency, types 1 and 2
- Carnitine uptake defect
- 2,4-Dienoyl-CoA reductase deficiency
- Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
- Medium-chain acyl-CoA dehydrogenase deficiency
- Medium-chain ketoacyl-CoA thiolase deficiency

- Medium/short-chain hydroxyacyl-CoA dehydrogenase deficiency
- Mitochondrial trifunctional protein deficiency
- Multiple acyl-CoA dehydrogenase deficiency
- Short-chain acyl-CoA dehydrogenase deficiency
- Very long-chain acyl-CoA dehydrogenase deficiency
- Glutaric acidemia, type 1
- 3-Hydroxy-3-methylglutaryl-CoA lyase deficiency
- Isobutyryl-CoA dehydrogenase deficiency
- Isovaleric academia
- Malonic academia
- 2-Methylbutyryl-CoA dehydrogenase deficiency
- 3-Methylcrotonyl-CoA carboxylase deficiency
- 3-Methylglutaconic academia
- 2-Methyl 3-hydroxybutyryl-CoA dehydrogenase deficiency
- Methylmalonic academia
- Mitochondrial acetoacetyl-CoA thiolase deficiency
- Multiple carboxylase deficiency
- Propionic academia
- Argininemia
- Argininosuccinic academia
- Citrullinemia
- Hyperammonemia/hyperornithinemia/homocitrullinemia
- Biotinidase deficiency
- Cystic Fibrosis
- Galactosemia
- Krabbe Disease

-Of children screened in 2009, there were 20 cases of amino acid disorders including PKU; 11 cases of congenital adrenal hyperplasia; 141 cases of primary congenital hypothyroidism; 20 cases of fatty acid oxidation disorders including MCAD; 271 cases of hemoglobinopathies; 42 cases of organic acid disorders including 3-MCC; 13 cases of biotinidase deficiency; 71 cases of cystic fibrosis, and 6 cases of galactosemia. Two infants were found to be at high risk for Krabbe disease.
-The Newborn Screening Program and the Children with Special Health Care Needs Program implemented standards for new types of Specialty Centers in 2002
-Prenatal Genetics Services were provided to 23,417 pregnant women in 2009.
-Another 23,609 individuals received Clinical Genetics Services through genetics services grantees.
-Wadsworth Center continued to provide certification of clinical and environmental laboratories serving NYS residents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 249,471 infants were screened for genetic disorders in 2009 by NYSDOH's Wadsworth Center's Newborn Screening Program. All newborns with a specimen submitted in NYS are tested for over 40 congenital conditions.		X	X	X
2. The Newborn Screening Program and the Children with Special Health Care Needs Program implemented and continues to monitor standards for Endocrine, Cystic Fibrosis and Inherited Metabolic Diseases Specialty Centers.				X
3. Prenatal Genetics Services were provided to 23,417 pregnant women in 2009.	X	X	X	X

4. Another 23,609 individuals received Clinical Genetics Services through genetics services grantees.	X	X	X	X
5. Comprehensive Prenatal/Perinatal Services Networks promote newborn screening and appropriate follow-up through newsletters and provider meetings.				X
6. NYMAC workgroups charged with educating the professional and lay public about genetics and newborn screening are developing the means to distribute new and existing materials.			X	X
7. Through the NYS Newborn Screening and NYMAC website, individuals concerned with genetics services or specialty care are able to access educational resources or identify clinical services providers, support groups and other needed services.		X	X	X
8.				
9.				
10.				

b. Current Activities

- Wadsworth Center conducts bloodspot screening on 100% of the state's newborns for conditions listed. 98% of referred infants are followed to confirmation.

-NYS provides grant awards to 24 genetic centers across the state to provide diagnostic services, laboratory testing, genetic counseling, and referral to treatment centers.

-NY is a member of the NY Mid-Atlantic Consortium (NYMAC) for Genetic & Newborn Services. NYMAC has formed 2 work groups with a focus on educating about genetics and newborn screening (NBS).

-The Genetic Services Program in Wadsworth Center is developing an assay to detect severe combined immunodeficiency syndrome.

-Hemoglobinopathy criteria for specialty centers was reviewed. Resulting standards are being implemented.

-The DFH was awarded the Effective Follow-up in NBS Grant for enabling health information exchange and improving communications regarding child health information. Goals are to:

-Improve NBS short-term follow-up via enhanced HIE among NBS, hospitals, medical home/community practices, and subspecialists.

- Develop long-term follow-up for Cystic Fibrosis (CF) and inherited metabolic diseases.
- Integrate NBS data within an interoperable model for meaningful HIE.
- Develop a child health profile.

-NBS EFU is piloting Remote Demographic Entry with hospitals for HL7 submission of demographic information, to improve accuracy and enable sample tracking, and is working with CF Centers to develop an electronic form for Remote Diagnostic Entry.

c. Plan for the Coming Year

-The Newborn Screening Program will continue to screen all newborn blood spots. UPS pick-up will continue with delivery at the Laboratory 5 days a week.

-The CSHCN and the Genetic Screening Programs will continue to monitor implementation and ensure appropriate follow-up services.

-NYSDOH Title V staff will remain involved in NYMAC activities.

-NYMAC and the Genetic Service Program will investigate ways to maximize resources/reimbursement for genetic services providers.

-Grant applications from submitters of plans for the transition of persons with sickle cell disease from pediatric to adult care settings will be reviewed, and funds awarded.

-Wadsworth Center will continue to assure that clinical public health laboratory services are available to the residents of New York State, including but not limited to: an anatomic pathology laboratory; a cytogenetic laboratory for diagnosis of prenatal and clinical abnormalities; and a laboratory for identification of reproductive and metabolic disorders.

-Wadsworth Center will continue to operate a state-of-the-art clinical and environmental

laboratory evaluation program to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests.
-The Newborn Screening Program will be expanding the Program to include primary T-cell immunodeficiencies. The Program will continue to follow-up on all positive findings.
-Article 28 hospitals will continue to be invited to apply for designation as Specialty Care Centers.
-Both through the NYS Newborn Screening website and the NYMAC website, individuals concerned with genetics or specialty care can access educational resources or identify clinical services providers, support groups and other public health resources: www.wadsworth.com/newborn; www.wadsworth.org/newborn/nymac
-NBS EFU will roll out the Remote Demographic Entry module to hospitals across NYS with a target of capturing at least 50% of all bloodspot screen data via electronic submission by the end of 2011.
-NBS EFU will implement the use of the Remote Diagnostic Form with Cystic Fibrosis Specialty Centers, and based on lessons learned from the CF form, will develop and implement a Remote Diagnostic Form for use by IMD Specialty Treatment Centers.
-NBS EFU will work with CF and IMD Specialty Centers to define criteria and goals for Long-term Follow-up, and implement a Long-term Follow-up tracking module in 2011.
-NBS EFU will work across organizations within the NYS Department of Health to enable the design and development of a health information exchange infrastructure. This infrastructure will also be used to support and populate a virtual child health profile, accessible by authorized users in both the private and public sector.
-NBS EFU will work with CHI² staff to coordinate activities for the design, development and implementation of a virtual child health profile.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**249471**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	249471	100.0	36	19	19	100.0
Congenital Hypothyroidism (Classical)	249471	100.0	1046	212	212	100.0
Galactosemia (Classical)	249471	100.0	10	5	5	100.0
Sickle Cell Disease	249471	100.0	73	73	73	100.0
Biotinidase Deficiency	249471	100.0	19	13	13	100.0
Congenital Adrenal Hyperplasia	249471	100.0	410	11	11	100.0
Cystic Fibrosis	249471	100.0	1551	69	69	100.0
Homocystinuria	249471	100.0	13	0	0	
Maple Syrup Urine Disease	249471	100.0	16	0	0	
HIV-1	249471	100.0	575	575	575	100.0

beta-ketothiolase deficiency	249471	100.0	0	0	0	
Tyrosinemia Type I	249471	100.0	9	1	1	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	249471	100.0	15	4	4	100.0
Isovaleric Acidemia	249471	100.0	12	1	1	100.0
Carnitine Uptake Defect	249471	100.0	6	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	249471	100.0	113	25	25	100.0
Glutaric Acidemia Type I	249471	100.0	17	3	3	100.0
Sickle Cell Anemia (SS-Disease)	249471	100.0	148	148	148	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	249471	100.0	33	5	5	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	249471	100.0	3	0	0	
Other Hemoglobin Disorders	249471	100.0	37	37	37	100.0
Carnitine Palmitoyltransferase I deficiency	249471	100.0	19	0	0	
Carnitine-acylcarnitine translocase deficiency	249471	100.0	6	1	1	100.0
2.4-Dieynoyl-CoA reductase deficiency	249471	100.0	0	0	0	
Short-Chain Acyl-CoA Dehydrogenase Deficiency	249471	100.0	15	9	9	100.0
Medium/Short chain Hydroxy Acyl-CoA Dehydrogenase Deficiency	249471	100.0	0	0	0	
Argenininemia	249471	100.0	4	1	1	100.0
Hemoglobin C Disease	249471	100.0	13	13	13	100.0
Malonic acidemia	249471	100.0	0	0	0	
PA/MMA/MCD/Cbl A,B,C,D/MUT	249471	100.0	40	3	3	100.0
Hyperammonemia / hyperonithinemia/homocitrullinemia	249471	100.0	10	0	0	
Krabbe Disease	249471	100.0	48	2	2	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62	64	66	66	60
Annual Indicator	60.3	60.3	59	59	59
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	62	63	64	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
-Maternal and child health programs, including the Early Intervention Program (EIP) and the Children with Special Health Care Needs (CSHCN) Program promotes family partnership in decision making at the individual, community and state levels.
-The CSHCN Program employs a Family Specialist, the parent of a young adult with special health care needs. The Family Specialist represented the family perspective in program planning, provided presentations about family involvement and engaged other family members to become involved in a cadre of family leaders by offering support and guidance.
-Engaging families in decision making is a key element of the EIP as families are required to agree to the services authorized on the child's Individualized Family Services Plan (ISFP). Each IFSP identifies the families' concerns, priorities and objectives for their child's development and then identifies the services needed to reach those objectives in the coming six months. Families' satisfaction with the program is inherently linked with the services received and their level of engagement in the program.
-The NYS Early Intervention Program plans and delivers the EIP Training Project for parents several times annually. This nationally-renowned leadership-training project helps parents of various diverse backgrounds to learn more about opportunities for parent involvement with the EIP. The training sessions provide information, resources, and skill-building activities designed to increase advocacy and leadership skills. The training is currently conducted twice a year, in different parts of NYS, over three separate weekends.
-The Title V Program continued to support a cadre of family representatives to serve as advisors to the Department for maternal and child health focus. These families have provided input into tools and resources for the CSHCN Program, served on committees, task forces and in community based quality improvement initiatives. Family Champions continue to provide feedback on the dissemination and use of previously developed family resource materials, including health summary tools and a resource directory, and provided input on a new Health Insurance Fact Sheet that described health insurance options for adolescents and young adults transitioning off their parent's insurance. One Family Champion has established a regional Family Champions group that offers a wide variety of parenting classes and support activities for families and provides a furniture and clothing closet to assist those in need.
-Families continued to serve as representatives on several state-level advisory groups, including the Emergency Medical Services for Children (EMSC) committee, the Early Intervention Coordinating Council (EICC) and the Commissioner's Cross Systems Committee, an interagency group that addresses the needs of children with multiple issues (medical, developmental, mental and behavioral conditions).
-Funds were offered as part of local CSHCN Program contracts to enhance consumer involvement in local CSHCN Programs. These funds can be utilized to provide consumer stipends, child care, travel reimbursement and other costs associated with consumer meetings and trainings. Twenty-eight local CSHCN contractors accepted these funds to strengthen family

involvement in their local programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program employs a Family Specialist which represented the family perspective in program planning, provided presentations and engaged other family members to become involved.				X
2. The Title V program supports a cadre of family representatives to serve as advisors and provided input into tools and resources for the CSHCN program and provide input to the program on the development, implementation and evaluation of resources and				X
3. The CSHCN Program continues to broaden parent input in policy development, improving access to health and related services for CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify services gaps.				X
4. Parents of CSHCN are represented on the MCHSBG Advisory Council and the Lead Poisoning Prevention Advisory Council, and serve as representatives on several other state-level advisory groups.				X
5. The CSHCN Program collects information about the needs expressed by families to assist with program evaluation and design.				X
6. Families participated in the Child Development Learning Collaborative with community practice teams.				X
7. The Health Insurance Fact Sheet was completed and posted to the Department's web site.		X	X	
8. Family Champions continue to provide feedback on the use of resource material and are assisting with the dissemination of the transitions website and curriculum in schools and communities.		X	X	
9. A series of community forums were held across the state to obtain input from families of children with special health care needs and youth with special health care needs.				X
10. Conference calls will be held with family/youth representatives and LHDs on topics concerning improving the ease by which families and youth can utilize the system of care for CSHCN.			X	

b. Current Activities

-Family representatives support state planning through advisory councils and committees. New family representatives, identified through the Title V Program's Family Champions group, were appointed to the MCHBG Advisory Council and the Lead Poisoning Prevention Advisory Council.
-Families were invited to participate in the Title V's Child Development Learning Collaborative with community practice teams.
-Family Champions provide feedback on the use of resource materials and are assisting with dissemination of the transitions website and curriculum. See NPM #06 for more detail.
-The Health Insurance Fact Sheet was completed and posted to the DOH Public Web site.
-A series of community forums were held in Spring 2010 to obtain input from families of CSHCNs and youth with special health care needs.
-Family representatives are also key stakeholders in the Early Intervention Coordinating Council (EICC), a statutorily-required advisory committee to the Early Intervention Program. Five of the

27 members are family representatives and EICC committeess are appointed to have equal representation of providers, families, state agency and municipal representatives.
-The Department received funding from HRSA for a State Implementation Grants for Improving Services for Children and Youth with Autism Spectrum Disorders in 2009. One of the objectives is to improve families' satisfaction with the services provided to their child with an autism spectrum disorder while in the EIP.

c. Plan for the Coming Year

-During the next FFY, family representation at the state level will continue on the EMSC, Early Intervention Coordinating Council, the MCHBG Advisory Council and the Lead Poisoning Prevention Advisory Council. Family input and representation will be sought when planning major program initiatives that involve families and children.
-Conference calls will be held with family/youth representatives and LHDs on topics concerning improving the ease by which families and youth can utilize the system of care for CSHCN.
-The CSHCN page of the Department of Health's webpage will be reviewed and updated with new publication and contact information.
-The EIP has allocated $800,000 of its ARRA-Early Intervention funding to expand family initiatives over the two year period ending in 2011. This funding will be used to develop a Web site (www.eifamilies.com) to include information and communication with all of the 70,000 families in the EIP, with links to existing programs sponsored by other state agencies, a blog which will allow readers to post commentary, news, or questions in an interactive format, learning opportunities through links to existing Web-based learning modules, and support opportunities through links to state and national Parent Centers. In addition to the Web site, the Early Intervention Partners Training Project will be expanded by conducting a third session of three additional weekends for each of the two years, conducting a Partners seminar to learn of successful leadership accomplishments and/or current status of former Partners graduates and by translating all material and handouts into Spanish.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52	55	58	58	46
Annual Indicator	51.7	51.7	45.2	45.2	45.2
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	48	49	50	50	51

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The CSHCN Program funds local health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs. Last year, 70 percent of children with special health care needs served by the CSHCN Program reported having a primary care provider, and almost 5 percent of contacts to the CSHCN Program resulted in referrals to obtain insurance (Medicaid or Child Health Plus), which is consistent with the proportion of families (6%) presenting to CSHCN without insurance.

Funds were offered as part of local CSHCN Program contracts to enhance consumer involvement in local CSHCN Programs. These funds can be utilized to provide consumer stipends, child care, travel reimbursement and other costs associated with consumer meetings and trainings. Last year, twenty-eight local CSHCN contractors accepted these funds to strengthen family involvement in their local programs

Title V staff collaborated with a New York City CATCH grantee to convene a community meeting to foster medical home implementation for CSHCN. Nineteen stakeholders, including representatives from family organizations (Parent to Parent of NYS), community practitioners and hospital providers and state and local agencies serving CSHCN attended. Discussion focused on barriers and perceptions related to medical home implementation and recommendations to consider for enhancing medical homes. Recommendations included training for pediatricians to learn about community agencies, their range of services and how to collaborate and coordinate care with these agencies. Toolkits, web site information or a 1-800- number for this information were deemed potentially helpful.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program funds local DOH's to provide information and referral to CSHCN and families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other services needs.		X		X
2. Funding to enhance and strengthen local CSHCN program contracts was provided to improve consumer involvement in local programs.		X		
3. Title V staff collaborated with a New York City CATCH grantee				X

to convene a community meeting to foster medical home implementation for CSHCN.				
4. New state law and funding support implementation of an initiative to incentivize patient-centered medical homes for persons enrolled in New York Medicaid.				X
5. The SBHC Quality Improvement Learning Collaborative was launched in 9/ 2009 to improve primary care through use of evidenced-based practices in the priority areas of comprehensive physical exams, overweight and obesity care, and asthma care.				X
6. The CSHCN Program funds local CSHCN Programs which integrate the medical home concepts into quality improvement initiatives. Local CSHCN Programs assist families to access insurance and a primary care provider.		X		X
7. SBHCs that participated in the Learning Collaborative will be encouraged to sustain improvements, share results and use the registry in the 2010-11 school year.				X
8. The CSHCN Program will meet with OHIP Medical Directors to discuss how to collaborate on the Medicaid medical home implementation and measurement opportunities relative to CSHCN.				X
9.				
10.				

b. Current Activities
Continued funding to localities as described above.

New state law and funding support implementation of an initiative to incentivize patient-centered medical homes for persons enrolled in New York Medicaid, pending CMS approval of a state plan amendment submitted in late 2009. Hospitals, clinics and practitioners that coordinate and integrate patient care in accordance with medical home standards will receive additional fee-for-service and managed care payments.

The School-Based Health Center Quality Improvement Learning Collaborative was launched in September 2009, with 25 teams participating. A kickoff webinar was held in September 2009, followed by two full-day regional learning sessions. The project focuses on improving primary care within SBHCs through use of evidenced-based practices in the priority areas of comprehensive physical exams, overweight and obesity care, and asthma care. The SBHC and CSHCN Program staff hold regular coaching sessions with the project teams. The project is continuing through the end of the 2009-2010 school year.

c. Plan for the Coming Year
The CSHCN Program will continue to fund contracts for local CSHCN Programs that provide information and referral to health insurance and medical homes. The medical home concepts are continuously interwoven into quality improvement initiatives. Upon a child's intake into the CSHCN Program, program staff will inquire whether a child has insurance and a primary provider. Regardless, local CSHCN Programs still will assist families to access insurance and a primary care provider.

Funds will continue to be offered as part of local CSHCN Program contracts for FFY 2011 to enhance consumer involvement in local CSHCN Programs. These funds can be utilized to provide consumer stipends, child care, travel reimbursement and other costs associated with consumer meetings and trainings.

SBHCs that have participated in the Learning Collaborative will be encouraged to sustain the improvements gained in 2009-2010, and use the registry for the three health indicators (Body Mass Index, asthma, comprehensive physical exams and age appropriate anticipatory guidance) and will share the results of the collaborative to other SBHCs in the 2010-2011 school year.

The CSHCN Program will meet with OHIP Medical Directors to discuss how to collaborate on the Medicaid medical home implementation and measurement opportunities relative to CSHCN.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	68	70	72	64
Annual Indicator	59.1	59.1	62.1	62.1	62.1
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	64	66	66	68	68

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The CSHCN Program funds local health departments (LHDs) to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other services needs.

The Department made available $3,685,000 in state aid through the Physically Handicapped

Children's Program for medical services to children birth to 21 years with severe, chronic illnesses or physically handicapping conditions. The gap-filling reimbursement is for services that insurance will not cover or do not cover fully. The children may be uninsured or underinsured and meet local program financial and medical eligibility requirements. In 2009, 639 children received diagnostic evaluation through the PHCP and 2,689 children received treatment services under PHCP. In descending order, the three major categories of service and percent of funds expended are as follows: 1) orthodontia (72 %), drugs (9%), and metabolic foods and formula (4%).

The CSHCN Program monitors the reasons why gap filling services are needed. The most common reasons for which families request PHCP assistance include: service is not covered (39 %), need help with copayment (4.9%), need help with premium (7.9%), need help with deductible (0.7%) and items exceeds the benefit package (4%).

The Early Intervention Program provided services to 74,000 infants and toddlers with disabilities or developmental delays and their families in 2009. Each family in the EIP is assigned an initial service coordinator who is required under regulation to identify other services in the community that the children and family could benefit from, which may often include enrollment in Medicaid, Home and Community-Based waiver programs, public assistance, supplemental nutrition through WIC or also primary care and other specialty services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN Program funds local DOH's to provide health information and referral to CSHCN and families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.		X		
2. DOH provided $3,685,000 in state aid through the Physically Handicapped Children's Program for medical services to children birth to 21 years with severe, chronic illnesses or physically handicapping conditions.		X		
3. In 2009, 639 children received diagnostic evaluation through the PHCP and 2,689 children received treatment services.		X		
4. The CSHCN Program monitors the reasons why gap filling services are needed.		X		
5. The EIP provided services to 74,000 infants and toddlers with disabilities or developmental delays and their families. Service coordination is provided to access services such as Medicaid, WIC, primary care and specialty services		X		
6. Title V staff contributed information to the DOH OHIP to support the development of state budget proposals to expand SCHIP coverage to include medically-necessary orthodontia, and continue to work with OHIP to support implementation.				X
7. Five regional family forums were conducted across the state to get input from families of CSHCN. Families reported specific concerns about the length of time required for prior approval of durable medical equipment.				X
8. The Resource Directory was updated to include information about the Home and Community-Based Medicaid Waiver Program (Bridges to Health) for children in foster care who have significant mental health, developmental disabilities or health needs.			X	

9. The Department continues to provide grant funding to support local CSHCN programs and annual state aid reimbursement to localities for gap-filling expenditures to assist families of children with special health care needs age birth to 21 years of age		X		
10.				

b. Current Activities
The Department continues to provide grant funding to support local CSHCN programs and annual state aid reimbursement to localities for gap-filling expenditures to assist families of children with special health care needs age birth to 21 years of age.

Title V staff contributed information to the Department's office of Health Insurance Program to support the development of state budget proposals to expand SCHIP coverage to include medically-necessary orthodontia, and continue to work with OHIP to support implementation.

Four regional family forums and one youth forum were conducted across the state to get input from families of CSHCN. Families reported specific concerns about the length of time required for prior approval of durable medical equipment.

In 2009 and continuing into 2010, the Resource Directory for Children with Special Health Care Needs was updated to include information about the Home and Community-Based Medicaid Waiver Program (Bridges to Health) for children in foster care who have significant mental health, developmental disabilities or health needs. The Resource Directory is available on the Department's web site and print copies are available via the on-line order form. The Resource Directory was translated into French, Spanish, Chinese, and Russian.

c. Plan for the Coming Year
Proposed state aid appropriations for state fiscal year 2010 remains level at $3,685,000. The PHCP will continue to monitor the number of children served and the type of services being funded through the gap-filling program.

New York's Early Intervention Program will continue to provide comprehensive services to infants and toddlers with, or at risk for, developmental delay or disabilities and their families.

The CSHCN Program will continue to disseminate information about the gap-filling program to families, providers and community-based organizations that serve families through its local CSHCN Program and on-line through the Department's web site.

The CSHCN Program will continue communication with OHIP to identify common gaps in coverage and explore options for coverage through public health insurance programs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	78	80	82	91	92
Annual Indicator	75.3	75.3	90.6	90.6	90.6
Numerator					
Denominator					

Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	92	92	93	93	94

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The Department provided grants to 57 contractors for the CSHCN Program to link families to appropriate state and community health-related programs and services, and help to identify and resolve gaps and barriers to care for children ages birth to twenty-one years.

The Department continued to engage Family Champions and Youth Advisors to provide feedback on the dissemination and use of family resource materials previously developed, including health information summary tools and a resource directory.

The Early Intervention Program provided services to 74,000 infants and toddlers with disabilities or developmental delays and their families in 2009. Each family in the EIP is assigned an initial service coordinator who is required under regulation to identify other services in the community that the children and family could benefit from, which may often include enrollment in Medicaid, Home and Community-Based waiver programs, public assistance, supplemental nutrition through WIC or also primary care and other specialty services.

The Department was a key member of the Interagency Task Force on Autism Spectrum Disorders (ASD), which issued a report detailing recommendations for ways for state agencies to better collaborate to deliver services to individuals with an ASD and their families. Transitions between service systems were identified by stakeholders as an area in great need of improvement.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DOH provided grants to 57 contractors for the CSHCN Program to link families to state and community health-related programs and services, and helps to identify and resolve gaps and barriers to care for children ages birth to twenty-one years		X		X
2. The Department continued to engage Family Champions and Youth Advisors to provide feedback on the dissemination and use of family resource materials previously developed, including health information summary tools and a resource directory.			X	X
3. Local health departments coordinate follow-up medical, educational and environmental services for children with lead poisoning.	X	X	X	X
4. The Title V Program is a key member of the Interagency Task Force on Autism Spectrum Disorders which issued a report detailing recommendations for improved collaboration among state agencies in delivering services.				X
5. The Governor's Children's Cabinet established an Early Childhood Advisory Council, in which the Department actively participates. The Council is assessing a variety of cross-systems priorities and strategies for streamlining information and services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Procured 5-year CSHCN contracts with 56 local health departments (LHDs).

Conducted regional family forums to obtain input on the system of care for CSHCN. Identified issues included transportation to medical services and the need for more information and communication about community resources and services.

LHDs coordinate follow up medical, educational and environmental services for children with lead poisoning

EIP provides service coordination (sc) for infants and toddlers and their families. The sc assists families through entry into the EIP to work through the multidisciplinary evaluation and development of the Individualized Family Services Plan. Ongoing sc ensures that families are supported through all aspects of the EIP and that EI services are coordinated with other family services and supports.

The Department has convened a Reimbursement Advisory Panel for the EIP to assess the current service delivery model in the program and the reimbursement methodology used, and recommend potential ways to improve it to better serve families in a way that is fair for providers and cost effective for all payors.

The Governor's Children's Cabinet established an Early Childhood Advisory Council, in which the Department participates. The Council is assessing cross-systems priorities and strategies for streamlining services for families with young children, including health, mental health, early care and education, parenting education, support and other systems.

c. Plan for the Coming Year
Continue to provide grants to localities for the CSHCN Program to offer information and referral services for families. Proposed level funding for the upcoming year.

Title V staff will meet with OHIP to share the resource and service concerns raised by families during the forums and to explore options to meet those needs.

A non-competitive procurement with Local Health Departments to provide preventive and follow up services for children with lead poisoning will be completed for another 5-year funding cycle to begin October 2010.

Early Intervention service coordination will continue to be offered to those children found eligible for the EIP.

Early Intervention will continue the work of the Reimbursement Advisory Council as well as work on services to children with autism to improve the system of services for infants and toddlers in the program and their families.

Title V staff will continue active participation in the Early Childhood Advisory Council

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	7	9	40	40
Annual Indicator	5.8	5.8	38.4	38.4	38.4
Numerator					
Denominator					
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	43	43	43	44

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

Youth advisors provided input and feedback about the development of a transitions website developed with support in part from the Department's Integrated Community Systems Grant. Youth advisors logged onto the development site, tested its operation, and provided input.

In July 2008, the CSHCN Program and its subcontractor, the Research Foundation of New York, SUNY Upstate, held an initial meeting with the State Education Department (SED) Transition Site Coordinators to discuss potential use of the transition website and curriculum within schools throughout NYS.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Youth advisors provided input on the transitions website developed with support in part from the Department's Integrated Community Systems Grant.		X		
2. In collaboration with the Research Foundation of New York, SUNY Upstate, completed development of a youth oriented, interactive website to help youth develop transition skills necessary to move from pediatric to adult health care.		X		X
3. The CSHCN program planned training sessions with school teaching staff to incorporate the transition website in their curriculum for students with disabilities.		X		X
4. Continue to promote the use of the transition website with local CSHCNs. Applicability and dissemination through other public health programs, including the Bureau's adolescent health programs, will be further explored		X	X	X
5. Lesson plans on skill building were posted through the transition website to 300 instructors of special needs programs in NYS schools. Evaluation strategies are being considered to determine the material's impact on positive youth transition.		X		X
6. A hand-held portable health summary (H.I.Doc) will continue to be available through the Department's Warehouse for distribution to consumers and providers who serve youth and young adults with special health care needs.			X	
7.				
8.				
9.				

10.				

b. Current Activities
In collaboration with the Research Foundation of New York, SUNY Upstate, completed development of a youth oriented, interactive website to help youth develop transition skills necessary to move from pediatric to adult health care. This website http://www.healthytransitionsny.org offers youth the opportunity to learn many new skills, i.e. making a doctor's appointment, managing medications, speaking up at a doctor's visit, setting health goals and finding community resources, through viewing brief videos.

Worked with SUNY Upstate to plan training sessions with school teaching staff to incorporate the transition website in their curriculum for students with disabilities.

Transition activities are included in the local CSHCN Programs' work plan template.

Family and youth were asked about the need for transition resources during public forums. Families and youth reported the transition resources developed by the CSHCN Program were helpful.

c. Plan for the Coming Year
Continue to promote the use of the transition website through a conference call with local CSHCN programs and promoting link from the Department's website. Applicability and dissemination through other public health programs, including the Bureau's adolescent health programs, will be further explored

Lesson plans related to transition skill building promoted through the transition website will be distributed to 300 instructors of special needs programs in NYS schools. Evaluation strategies will be considered to determine the impact of distribution of this material on positive youth transition.

Transition activities will remain part of the CSHCN Programs' work plan template for 2010-2011.

A hand-held portable health summary (H.I.Doc) will continue to be available through the Department's Warehouse for distribution to consumers and providers who serve youth and young adults with special health care needs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	86	87	88	80
Annual Indicator	81.6	83.5	83	76.2	76.2
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report					

the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	82	82	84	84

Notes - 2009
2008 data are being used as a proxy for 2009.

Notes - 2008
Data from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 1-08-12-08.

Notes - 2007
Data from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 1/07-12/07.

a. Last Year's Accomplishments
The National Immunization Survey (NIS) rates have decreased, in part, due to changes in the survey methodology. Decreasing prevalence of families with land lines (the NIS is a telephone survey) and a small sample size contribute to the variability of the results (confidence intervals are in the 4--6% range).

The Immunization Program provided vaccines through the NYS Vaccines for Children (VFC) Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to expand the statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional offices and to purchase vaccines. Local health departments assist in recruiting VFC providers.

Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, instead of public clinics. Under the Assessment, Feedback, Incentives and eXchange (AFIX) initiative, local health department staff visit health care providers to assess the medical records of their patients for compliance with immunization schedules. The information is entered in CDC-developed software called, the Comprehensive Clinic Assessment Software Application (CoCASA). CoCASA calculates the providers' immunization rates and identifies opportunities for improvement in immunization practices.

Comprehensive Prenatal/Perinatal Services Networks provide education and outreach to engage children into the health care system. Some networks conducted outreach for Child Health Plus and other outreach and educational activities to ensure that parents are aware of the need for comprehensive immunization.

Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.

Up-to-date immunizations were provided to over 600 children in migrant day care settings in NYS.

The Community Health Worker Program educated parents about immunization, assessed the immunization status of all children in the program, referred and assisted families to obtain

immunization, and followed-up with families to assure they actually received the service. Assistance is given with insurance enrollment. In 2008, 76% of the children entering the program had up-to-date immunizations. Of the children who did not have complete immunizations, 91% received immunizations while in the program. A total of 80.3% had complete immunizations.

The Prenatal Care Assistance Program and Medicaid Obstetrical Maternal Services program educated parents in the need for preventive services, including immunization. Assistance is given with health insurance enrollment.

In WIC, all infants and children are screened until all marker immunizations are received. Infants and children not adequately immunized must be referred to a health care provider or immunization clinic.

Child care providers in NYS are required to check immunizations and refer as appropriate.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Bureau of Immunization provided vaccines through the NYS Vaccines for Children Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted providers.			X	X
2. Under the Assessment, Feedback Incentives and eXchange (AFIX) Initiative, county staff visit pediatric providers and assess immunization records.			X	X
3. Comprehensive Prenatal/Perinatal Services Networks provided education and outreach to engage children into the health care system.		X	X	X
4. Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies			X	X
5. Up-to-date immunizations were provided to over 480 children in migrant day care settings in NYS.	X	X		X
6. The Community Health Worker Program educated parents about immunization, assessed the immunization status of children, referred and assisted families to obtain immunization, and followed-up with families to assure receipt of vaccines.		X		X
7. PCAP and MOMS also educated parents in the need for preventive services, including immunization. Assistance is given with health insurance enrollment.		X	X	X
8. In WIC, immunization records are reviewed and infants and children who are not up-to-date are referred to health-care providers or immunization clinics.		X	X	X
9. The Perinatal Hepatitis B Program has increased the universal birth dose in all birthing hospitals outside NYC to 75% by providing free vaccine for all children regardless of insurance coverage.				X
10.				

b. Current Activities

The New York State Immunization Information System (NYSIIS) was launched in February 2008 and continued to experience tremendous growth during 2009. 80% of providers who immunize children are participating in the system. NYSIIS contains more than 3 million patients and 35 million immunizations. As the statewide, web-based immunization information system, NYSIIS enables health care providers to identify and track under-immunized children and increase immunization rates.

c. Plan for the Coming Year
NYSIIS continues to grow towards a fully-functioning, comprehensive population-based system. Further development and enhancement of the system is planned for the coming year, including integration with other internal child health data systems and increased capacity for external health information exchange. In addition, data are being assessed for completeness, accuracy and timeliness of reporting and these data will be used to determine areas of need for additional immunization related program activities.

The Perinatal Hepatitis B Program is identifying best practices by surveying all birthing hospitals that have a 90% and above birth dose vaccination rate. Once the survey is complete and the data is analyzed, the Bureau of Immunization will use the information to promote the universal birth dose of hepatitis B vaccine for all newborns in NYS.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	12	11	11	12.5
Annual Indicator	13.7	13.1	13.2	12.9	12.9
Numerator	5332	5214	5277	5074	5074
Denominator	390618	398091	398693	392716	392716
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12.3	12.1	11.9	11.9	11.8

Notes - 2009
2008 data are being used as a proxy for 2009.

a. Last Year's Accomplishments
Vital Statistics data for 2008 demonstrate continued accomplishments and challenges in teen pregnancy and birth rates. Birth rate for teens age 15-17 years declined to a new low of ____. Significant geographic, racial and ethnic disparities in teen birth rates exist, but the magnitude of the disparities is declining.

51 family planning agencies with 189 clinics provided free or low cost contraceptive services to nearly 343,000 women, including nearly 100,000 teens.

Several projects to support the use of emergency contraception (EC) were conducted, including collaboration with ACOG for education and media campaigns to reach OB/GYN providers, supplemental funding to family planning providers and School-Based Health Centers (SBHCs) to distribute EC, and development of educational materials for the public and pharmacists.

A preconception care packet, including a checklist and Preconception Care Guide, was developed in collaboration with the ACOG NY, Region II, and distributed to over 16,000 obstetricians/gynecologists, nurse practitioners, and pediatricians specializing in adolescent health. The materials encourage medical professionals to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes.

Community Based Adolescent Pregnancy Prevention (CBAPP) programs provide pregnancy prevention services in targeted high risk zip codes. CBAPP employs a comprehensive model that includes: sexual health education to delay onset of sexual activity and reduce risky sexual behavior; educational, recreational and vocational opportunities as alternatives to sexual activity; and access to family planning services.

The Adolescent Pregnancy Prevention and Services (APPS) Program continues to provide education, case management, prenatal support and parenting education to teens in high need communities.

Comprehensive Prenatal/Perinatal Services Networks conduct community education and outreach activities to improve the reproductive health of all women, including teens.

The Rape Crisis Program developed and implemented a Sexual Violence Primary Prevention Committee whose 30 member agencies meet quarterly to identify and address issues related to sexual violence. DOH also provided funding to rape crisis providers across NYS to support activities related to the primary prevention of sexual violence.

SBHCs are in high-need underserved communities across the state. Age-appropriate risk assessment and anticipatory guidance and health education pertaining to sexual activity is a part of the initial assessment and annual comprehensive physical exam for students enrolled in a SBHC. When indicated, students have access, either onsite or through referral, to family planning services and pregnancy testing.

The ACT for Youth Center of Excellence (COE), funded by DOH, is a collaboration between Cornell University, University of Rochester School of Medicine, NYS Center for School Safety and NYC Cornell Cooperative Extension, providing information, training and technical assistance statewide to youth serving providers regarding Positive Youth Development and evidence-based approaches toward teen pregnancy prevention.

A teen sexual health focus group study was conducted by the COE for DOH to learn about how NYS youth get information about sexual health, how they access sexual health care services and ideas for improving services. Focus group sites were chosen with particular attention paid to diversity. A total of 291 youth participated in 27 focus groups across the State.

DOH convened a symposium on teen sexual health with the COE. The symposium was convened with experts on teen sexual health, key stakeholders and youth. Dr. Jonathan Klein, Assoc. Executive Director of the American Academy of Pediatrics, provided the professional leadership for the event.

The symposium and focus groups elicited input from researchers, practitioners and youth on recommendations for future programming. Themes included maximizing the use of communication technologies; increasing comprehensive sexuality education; incorporating multi-level ecological approaches that meet teen's needs and providing a full range of coordinated services delivered efficiently and accessibly.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 51 family planning agencies with 189 clinics provided free or low cost contraceptive services to nearly 343,000 women, including nearly 100,000 teens.	X	X	X	X
2. A preconception care package were developed and distributed to 16,000 OB/GYNs, nurse practitioners, and pediatricians to assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes.			X	
3. CBAPP programs provide pregnancy prevention health education services in targeted high risk zip codes to delay onset of sexual activity and reduce risky sexual behavior.	X	X	X	X
4. SBHCs are in high-need underserved communities across the state. Age-appropriate risk assessment and anticipatory guidance, and health education on sexual activity are part of exams for students enrolled in a SBHC.	X	X		
5. A total of 291 youth participated in 27 focus groups across the State to learn about how youth get information about sexual health, access sexual health care services and ideas for improving services.				X
6. The Department formed an Adolescent Sexual Health Work Group to develop a coordinated approach to improving sexual health outcomes for teens.				X
7. A new teen sexual health initiative that will emphasize evidence-based comprehensive sexuality education, access to reproductive health services, multi-dimensional support for life skills development and community collaboration is being launched.				X
8. The Department developed and launched a media campaign that includes sexual health promotion messages that address pregnancy, STD, and HIV. The campaign includes a new youth-friendly sexual health web site (www.nysyouth.net)				X
9.				
10.				

b. Current Activities

All program activities described above continue with additional activities described below.

The DOH Adolescent Sexual Health Work Group (ASHWG) was formed to develop a coordinated approach to improving sexual health outcomes for teens. ASHWG is comprised of staff from a wide range of DOH units.

Additional funds (formerly used for abstinence-only programs) were utilized to enhance and expand CBAPP.

The COE began monthly webinars with CBAPP and APPS providers on such topics as male

involvement in pregnancy prevention, needs of youth in foster care, and gang involvement.

As a result of the information gathered through the symposium, focus groups and internal discussions, an RFA will be released for a new teen sexual health initiative that will emphasize evidence-based comprehensive sexuality education, access to reproductive health services, multi-dimensional support for life skills development and community collaboration.

The family planning program will release an RFA to solicit the NYS Family Planning Program for the next 5 year funding cycle. The statewide network of Family Planning and Reproductive Health Care providers continue to provide comprehensive services to NY's most vulnerable populations. See SPM #4.

The ASHWG developed and launched a media campaign that includes sexual health promotion messages that address pregnancy, STD, and HIV. The campaign includes a new youth-friendly sexual health web site (www.nysyouth.net) managed by the COE.

c. Plan for the Coming Year

Ongoing program activities to support a wide range of clinical and community-based services will continue next year, with anticipated changes described below.

Title V staff will continue to actively participate in the Adolescent Sexual Health workgroup described above.

A new 5-year grant funding cycle for the New York State Family Planning Program will begin in January 2011. See SPM #4.

A 5-year grant funding cycle for the new Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative will begin January 2011. This new initiative will combine the current CBAPP and APPS programs. Funding will target the areas of the state with the highest burden of teen pregnancy and births, STDs and other individual, family and community factors that contribute to poor adolescent sexual health outcomes. Programs will be required to implement evidence-based programming, increase access to reproductive health services, support life skill development, and collaborate with other community organizations to support adolescent development.

The new Web site (nysyouth.net) launched as part of the current media campaign will continue and be further enhanced to include additional information on adolescent health and related issues, including topics to be identified through youth feedback on the site.

Work will continue to develop approaches in preconception health including cross agency collaborations with other programs and Bureaus such as the Bureau of Chronic Disease and Prevention.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40	30	35	40	28
Annual Indicator	27.0	27.0	27.0	27.0	27.0

Numerator	10534	10534	10534	10534	10534
Denominator	39014	39014	39014	39014	39014
Data Source				NYS 3rd Grade Dental Survey	NYS 3rd Grade Dental Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	39	39	30	31	31

Notes - 2009
2002-2004 data are being used as a proxy for 2007

Notes - 2008
2002-2004 data are being used as a proxy for 2007.

Notes - 2007
2002-2004 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
For more than 25 years, the Department of Health has promoted school-based dental sealant programs in targeted areas to increase the prevalence of sealants. To assist in the establishment of new school-based programs, the guidelines, application, and performance evaluation review tool for school-based dental programs were revised and enhanced and posted to the Department public website.

The Centers for Disease Control and Prevention (CDC) has developed criteria for targeting school-based dental sealant programs to reach the greatest number of children in high need areas most affected by dental caries and untreated decay, and least likely to have sealants. School-based dental sealant programs target schools in urban areas where 50% or more of the student population is participating in the free or reduced-cost lunch program. In rural school districts, sealant programs are targeted to schools in which the median family income is at or below 235% of the federal poverty level. An analysis of elementary school lunch and median family income data from the National Center for Education Statistics of the U.S. Department of Education was conducted to assess the number of schools that meet the CDC criteria. Based on these criteria, of the 4,669 elementary schools in New York State, 2,316 (50%) are eligible for sealant programs.

During 2009, a total of 38 school-based dental health center programs provided oral health education, dental examinations, prophylaxis, sealants and referrals for needed treatment services to children at 560 schools in high need areas throughout the State. This represents services being available at 24.2% of all schools eligible for a sealant program.

To assess the attitude of dentists toward the use of sealants, analysis of a survey of private dentists in general practice was conducted. Several actions were identified to promote utilization of dental sealants among private dentists. These include expansion of school-based sealant programs, increasing awareness about sealants through education campaigns for parents, and targeting high risk children, the last two of which can be accomplished through expanding school-based sealant programs.

An Access Database was developed to record quarterly and annual report data from all school-based dental programs on the full array of oral health services provided, including the application of dental sealants. All quarterly and annual reports received to date were entered into the database and will be used to evaluate the services provided.

The Bureau of Dental Health worked closely with the New York City Department of Health and Mental Hygiene (NYCDHMH) staff and numerous City dental care providers serving low income populations to transfer the responsibility for operating school-based dental programs from the city health department to other providers, as a result of NYCDHMH's decision to close all of its school-based dental programs and community-based dental clinics. The Bureau was successful in finding a provider for 41 out of 56 schools.

As part of the surveillance effort to assess needs, approval was obtained from the Institutional Review Board for screening a representative sample of third grade children. The Bureau contracted with the Technical Assistance Center at the Rochester Primary Care Network to recruit and train dental hygienists, and conduct the survey.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Oral health preventive services are provided to eligible students. There are currently 42 school-based dental programs providing oral health services to children at 625 schools in high need areas across the State.	X		X	
2. Three webinars were conducted to provide training to staff in school-based dental programs. Topics included application process for obtaining approval, infection control and guidelines for school-based dental sealant programs.			X	
3. Collaborative efforts continue with the New York State Oral Health Coalition, Medicaid and Child Health Plus on improving access to dental care.			X	
4. Plans to expand the 3rd grade surveyto include NYC and additional schools in Upstate New York. Data will be made available to community partners and local health departments in order to better target oral health services to those most in need.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Oral health preventive services continued to be provided to eligible students. There are currently 42 school-based dental programs providing oral health services to children at 625 schools in high need areas across the State. This represents services being available at 27% of all schools eligible for a sealant program.

NYS passed legislation effective with the start of the 2008-09 school year requiring public schools to request a dental health certificate for students entering grades K, 2, 4, 7, and 10. The Bureau compiled a list of dental clinics willing to accept referrals from schools and a website was developed http://www.nyssmiles.org for public information.

Three webinars were conducted to provide training to staff in school-based dental programs. Topics included application process for obtaining approval, infection control and guidelines for school-based dental sealant programs.

A Request for Applications (RFA) for school-based dental sealant programs in underserved, high need areas of the state is under review and is anticipated to be issued early summer 2010.

Collaborative efforts continue with the New York State Oral Health Coalition, Medicaid and Child Health Plus on improving access to dental care and the establishment of a dental home for all children by age one.

The Bureau applied for an ARRA grant for equipment to enhance training for health professionals to support oral health workforce activities.

c. Plan for the Coming Year

The Bureau plans to issue an RFA to promote the use of dental sealants, and establish and execute contracts with new providers for the creation of school-based dental and sealant programs.

Plans are underway to expand the survey of 3rd grade children to include New York City and additional schools in Upstate New York. Data will be made available to community partners and local health departments in order to better target oral health services to those most in need. Data from the third grade survey will be analyzed and a report will be provided to counties.

If the HRSA grant application is funded for the purchase of dental equipment, then the Bureau will issue a Request for Application for equipment, assess the merits and award equipment grant. A vendor will be selected for the purchase of equipment. Webinars will be conducted to provide training for dental hygienists regarding the use of dental equipment.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.5	1.1	1	0.9	1.3
Annual Indicator	1.3	1.3	1.3	1.2	1.2
Numerator	49	50	48	43	43
Denominator	3790880	3916635	3597289	3604140	3604140
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	1.2	1.2	1.2	1.2	1.1

Notes - 2009
2008 data are being used as a proxy for 2009 data.
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

Notes - 2008
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

Notes - 2007
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

a. Last Year's Accomplishments
Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues related to childhood injury prevention.

The Bureau of Injury Prevention performs traffic related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS. The Bureau of Injury Prevention also represents the Department on the Governor's Traffic Safety Committee.

The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. 2005 NYS data show that motor vehicle crashes accounted for 19.8% of all pediatric trauma cases and are responsible for the largest percentage of all pediatric dead-on-arrival cases (about 35%).

The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled in the Community Health Worker Program are also given extensive information about childhood safety. Homes are assessed for hazards and workers role model positive parenting skills and behaviors.

American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduction.

PCAP and MOMS have an extensive health education agenda, including infant and child safety, use of safety seats, and burn prevention and other causes of infant injuries.

All school-based health centers provide screening for psychosocial and health risk assessment beginning with the initial visit. Additionally, age appropriate anticipatory guidance is provided in a typical encounter which includes student and family education about safety issues and injury prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Childhood Injury Prevention Projects have built successful coalitions for injury control at the local level, reaching out to			X	X

diverse segments of the community to ensure that the populace is well informed on issues.				
2. The Bureau of Injury Prevention performs traffic related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS. The Bureau of Injury Prevention also represents the Department on the Governor's Traffic Safety Committee			X	X
3. The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and further enhance the pediatric trauma care system. Motor vehicle crashes account for 19.8% of all pediatric trauma cases.			X	X
4. The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled with Community Health Workers are given extensive safety information		X	X	X
5. American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters.		X	X	X
6. SBHC's provide screening for psychosocial issues and complete health risk assessment beginning with the initial visit. Additionally, age appropriate anticipatory guidance is provided which includes education about safety issues and injury prevention.	X	X		
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau of Injury Prevention is completing development of tool kits and fact sheets to provide up to date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly traffic related, for medical providers, researchers, educators and consumers. The toolkits include Shaken Baby Syndrome prevention, fire safety, falls prevention, child passenger safety, and bicycle safety. The toolkits will be available on the NYSDOH website and in hard copy upon request.

Partnerships with other agencies and organizations with a focus on childhood injury prevention continue to thrive, promoting a coordinated message.

A supplemental grant award from the CDC is supporting the development of a child injury prevention policy initiative.

A symposium was held in winter 2010 for practitioners describing the problem of child injuries and introducing the toolkits. A second symposium is planned for spring 2010 to educate practitioners and provide the tools necessary to develop strategies for childhood policy promotion on the state and local level.

A Child Injury Prevention Policy Subgroup of the larger Injury Community Planning Group has met to discuss and prioritize policy initiatives of importance to reduce the risk of injury in NYS families with children from 0-19 years. A Child Injury Policy Plan is being developed including the relevant data, evidence-informed strategies and best practices and prioritized list of policies and

timeline.

c. Plan for the Coming Year
The Bureau of Injury Prevention will continue to conduct a Childhood Injury Prevention Campaign. As requested by stakeholders in LHDs and other community-based organizations, regional training workshops will be conducted in four locations across the state during 2011. The purpose of the workshops will be to educate practitioners about the usefulness of policy measures to support evidence-informed interventions and best practices to reduce the risk of childhood injury. Partners participating in the Child Injury Prevention Policy Subgroup (CIPPS) will provide expertise and support by encouraging their local offices to participate.

A one-day traffic safety symposium will be held to educate stakeholders about the risk of sustaining a traumatic brain injury from a motor-vehicle related incident. Relevant data and evidence-informed strategies and best practices will be shared with the participants.

The CIPPS will complete a Child Injury Policy Plan to guide future efforts for addressing child policy initiatives.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		40	43	51	44.5
Annual Indicator	37.2	50	50	49.4	49.4
Numerator					
Denominator					
Data Source				National Immunization Survey - breastfeeding suppl	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45.5	47	48	49	50

Notes - 2009
2008 data are being used as a proxy for 2009 data.

Notes - 2008
2008 data are based on the 2006 birth cohort.
Data Source: National Immunization Survey - breastfeeding supplement

Notes - 2007
2007 data are based on the 2004 birth cohort.
Data Source: National Immunization Survey - breastfeeding supplement

a. Last Year's Accomplishments
In recognition of the importance of breastfeeding, the NYS Legislature enacted and the Governor signed into law the Breastfeeding Mothers' Bill of Rights, which specifies the rights of pregnant women and new mothers to be informed about the benefits of breastfeeding, and to obtain specific supports from health care providers and health care facilities during pregnancy, after delivery and after discharge from the birthing facility. The new law subsequently went into effect on May 1, 2010.

In an effort to improve exclusive breastfeeding rates in maternity hospitals in New York, infant feeding data from hospitals (excluding New York City) was analyzed using the Statewide Perinatal Data System. Hospitals were ranked by quintile scores on three breastfeeding indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants). Each hospital was informed of their performance relative to other hospitals. The written breastfeeding policies and procedures, as specified in state regulation, were collected from all hospitals providing maternity care services in the state. The policies were reviewed to determine compliance with the 32 components required by State regulations, and each hospital was informed on their individual compliance with each component of the regulations.

In 2009, the Department electronically surveyed all 138 hospitals that provide maternity services in NYS. Information regarding patient education and support, obstetric staff education and training, and general breastfeeding polices was collected. The study identified several differences in breastfeeding practices at hospitals providing maternity services in NYS. Recognition of these differences will be used to inform policy decisions and training opportunities for obstetric staff across the state. In preparation for such training, hospital staff were surveyed to determine the best staff education options related to breastfeeding.

In January 2009, the NYS WIC Program (overseen by the Division of Nutrition's Bureau of Supplemental Food Programs) became the first program in the country to implement newly redesigned WIC food packages. In following the Department's goals and the American Academy of Pediatrics (AAP) recommendation that breastfeeding continue for 1 year and beyond, WIC took into consideration the mother and infant to design a food package to meet their combined nutritional and energy needs. Extended food benefits are available to the exclusively breastfeeding mother for the first year of breastfeeding (instead of six months). The breastfeeding infant food packages (6 months and older) delay the introduction of juice and cereal, and provide baby vegetables, fruits and meats as further incentive for mothers to continue breastfeeding. By providing this support, mothers may be more likely to initiate and continue breastfeeding. When mothers do not plan to exclusively breastfeed, a "partial breastfeeding" option is available after the infant turns 1 month old. As a result, the food package is adjusted according to the amount of formula the infant receives.

The new food packages coincided with WIC's initiatives to enhance breastfeeding support and provide participant centered nutrition education. The Request for Applications to select agencies that will provide WIC Program services included requirements for local agencies to promote and support breastfeeding as a priority core service. These services include support from WIC staff members trained in lactation counseling and peer-counseling services for pregnant women and new mothers. The literature shows that peer counseling is one of the most successful interventions for increasing breastfeeding among low-income women. Other support services include the availability of breast pumps to mothers who are returning to work or have other special needs. The www.breastfeedingpartners.org website was developed specifically to answer mothers' questions and provide additional training to peer counselors.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. New York enacted the Breastfeeding Mothers' Bill of Rights law on 5/1/10 which requires pregnant women and new mothers to be informed about the benefits of breastfeeding and obtain specific supports from health care providers and health care faciliti			X	
2. Using data from SPDS, hospitals were ranked by quintile scores on three breastfeeding indicators (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breastfed infants). Each hospital was informed of their performance r				X
3. NYS WIC Program implemented newly redesigned WIC food packages, following DOH goals and the American Academy of Pediatrics recommendation that breastfeeding continue for 1 year and beyond.			X	X
4. WIC developed and implemented initiatives to enhance breastfeeding support and provide participant centered nutrition education, requiring agencies that will provide WIC Program services promote and support breastfeeding as a priority core service.			X	
5. The Department and Regional Perinatal Centers are offering the Ten Steps to Successful Breastfeeding Online Course (18-hour course) to staff in 125 obstetrical hospitals across NYS.			X	
6. For the Breastfeeding Quality Improvement in Hospitals Learning Collaborative with the NICHQ, DOH is recruiting 12 hospitals and NYC DOHMH recruiting 8 hospitals to develop a culture within the hospital to promote exclusive breastfeeding.			X	X
7. The Breastfeeding Mothers' Bill of Rights was posted on the DOH website in 6 languages.			X	
8. A collaborative effort among DOH Divisions and Offices and the NYC DOHMH will continue to educate and implement baby friendly policies and practices, link women with home visiting programs and assist with support for breastfeeding.			X	X
9. As part of the Public Health Detailing Project, a public awareness campaign will be implemented to educate women on the benefits of breastfeeding, increase access information and resources, and provide support for nursing women in the workplace.			X	
10. Through the Breastfeeding Quality Improvement initiative Certified Lactation Counselors will be trained in hospitals.			X	X

b. Current Activities

The Department and Regional Perinatal Centers are offering the Ten Steps to Successful Breastfeeding Online Course (18-hour course) to staff in 125 obstetrical hospitals across NYS.

DOH is recruiting 12 hospitals located outside NYC for the Breastfeeding Quality Improvement in Hospitals Learning Collaborative, a joint initiative with the NICHQ. The NYC DOH is recruiting 8 hospitals located in NYC for a similar initiative. The purpose will be to recruit teams from these hospitals to develop a culture within the hospital to promote exclusive breastfeeding.

The Breastfeeding Mothers' Bill of Rights was posted on the DOH website in 6 languages.

New WIC agencies receive intensive assistance to ensure quality breastfeeding promotion and support services, including implementation of Breastfeeding Peer Counselor Programs.

Public Health Detailing expanded statewide, training WIC staff to visit local health care providers and offer materials on breastfeeding support, peer counseling and other services at WIC clinics.

The USDA gave $1.6 million to NYS WIC to recognize its high rate of breastfeeding initiation. About 74% of NYS WIC mothers initiated breastfeeding, compared to the national rate of 62% for WIC mothers; 41% of NYS WIC mothers breastfeed for at least six months, compared to 27% for the US.

NYS WIC offers Certified Lactation Counselor (CLC) training to local WIC staff, and participates in a pilot to expand CLC training to hospital staff statewide.

c. Plan for the Coming Year

Collaboration among the Department's Division of Family Health, including the Office of the Medical Director, and the Bureau of Maternal and Child Health, and the Division of Nutrition, the Division of Chronic Disease Prevention, and the New York City Department of Health and Mental Hygiene will continue to educate providers, assist hospitals with the implementation of baby friendly policies and practices, and to link women with home visiting programs during the perinatal period to educate and assist with support for breastfeeding.

Through the Communities Putting Prevention to Work (CPPW) funded Breastfeeding Quality Improvement initiative, the Department aims to further improve hospital policies and practices, promote hospital compliance with NYS regulations and laws, and increase staff skills and knowledge. This includes supporting the training for one staff per participating hospital to become a Certified Lactation Counselor, and training WIC staff to increase their knowledge and skills in supporting and educating mothers of their rights provided under NYS's Nursing Mothers in the Workplace Act. Website resources will be developed for women, health care providers and employers to increase their access to current information and resources on breastfeeding, and in particular, providing support for nursing women in the workplace.

The Maternity Information Leaflet, required by state law, provides patients information on maternity related procedures performed at each hospital. It has now been expanded to also require that information on infant feeding practices at each hospital (breastfeeding initiation, exclusive breastfeeding, and formula supplementation of breast-fed infants) be included.

The Division of Nutrition (DON) has invested substantially in breastfeeding promotion. The program now requires that a Certified Lactation Counselor, in addition to peer counselors, be available at all WIC clinics to provide breastfeeding education and lactation support. Fully, $5 million in peer counseling programs have been implemented to improve breastfeeding rates among women receiving WIC.

DON will initiate a public awareness campaign to support breastfeeding women. The campaign is supported with CPPW funding (WIC Breastfeeding Performance Bonus Award) in recognition of NYS high rates of breastfeeding among women who participate in the WIC program. To build general community awareness of how WIC provides support for breastfeeding families, WIC will launch a campaign that will include TV ads, radio and print, including bus sides, shelters and billboards. As part of the Public Health Detailing Project, materials will be produced and distributed that health care providers can use in educating women on the benefits of breastfeeding. These materials will include information on resources that will help support families in their breastfeeding efforts.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.8	97.9	98.5	98.7	98.7
Numerator	242628	242212	247960	244630	244630
Denominator	245675	247352	251760	247928	247928
Data Source				Newborn Hearing Screening Program	Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
2008 data are being used as a proxy for 2009.

a. Last Year's Accomplishments
The Department receives grant funding from HRSA to expand and improve the Universal Newborn Hearing Screening and Intervention (UNHS) program to assure quality developmental outcomes for infants identified with hearing loss. Most recently, letters were sent to all 144 birthing facilities in New York State, comparing individual hospital performance to statewide performance and the Joint Committee on Infant Hearing benchmarks. Fifteen hospitals were required to submit corrective action plans to the Department. Staff completed a review of the policies and procedures submitted by the hospitals and, in some cases conducted follow up conference calls or visits to the hospitals.

The Department received the second year of three years of funding from the Centers for Disease Control and Prevention for the Early Hearing Detection and Intervention Tracking, Surveillance, and Integration project. Through this project, the Department is improving its mandated Universal Newborn Hearing Screening and Intervention Program by linking existing child health data system within the Department to better track individual level screening and audiologic data, and referral information.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Universal Newborn Hearing Screening and Intervention			X	

(UNHS) program will be expanded and improved to assure quality developmental outcomes for infants identified with hearing loss.				
2. Existing child health data systems within the Department will be linked to better track individual level screening and audiologic data, and referral information.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department is authorized to collect, and all birthing facilities are required to provide, aggregate data on newborn hearing screening results each quarter for all infants born in New York State. The collection of aggregate data significantly impacts the Department's ability to follow up on infants who potentially have a hearing loss. As a result, the Department is seeking state legislation that will require hospitals and other health care providers that perform or order newborn infant hearing screenings to report results through a statewide information system; authorize the collection and storage of newborn infant hearing screening results and data in a statewide information system; and authorize access to such data in order to increase newborn infant hearing screening rates and improve the completeness and accuracy of newborn infant hearing screening data.

c. Plan for the Coming Year

If legislation is enacted as proposed above, the Department will be actively involved in implementing the legislation over the coming year. Much of the work to design requirements for the data systems for submission of data, and storage in the Department's child information system has been completed, but cannot be built until legislation is enacted.

The Department also is preparing a Notice of Proposed Rulemaking seeking to change regulations for the Newborn Hearing Screening and Intervention program for the first time since regulations were adopted in 2000. These revised regulations will include changes needed to collect individual level data and other corrections to support improved practices by facilities that have been learned over the last decade of working closely with hospitals to improve screening performance.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	8.5	8	8	8.5
Annual Indicator	7.7	8.4	8.9	7.1	7.1
Numerator	347000	380000	395000	310000	310000
Denominator	4534000	4547000	4437000	4373000	4373000
Data Source				Current Population	Current Population

				Survey	Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8.4	8.2	8	8	6

Notes - 2007

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a. Last Year's Accomplishments

New York has made significant progress in providing access to health insurance to all children and teens. With expansion of Child Health Plus (the State's SCHP program) to 400 percent of the federal poverty level in September 2008, all uninsured children and teens are eligible for comprehensive and affordable health insurance through Medicaid and Child Health Plus. More than 90 percent of the state's uninsured children are eligible for subsidized coverage and the remaining children are able to buy into the Child Health Plus program.

Enrollment gains in Medicaid and Child Health Plus -- New York has witnessed a steady increase in children's enrollment since January 2008. Enrollment of children in Medicaid and Child Health Plus grew by 151,000 children between January 2008 and September 2009 (most recent data available for combined enrollment). More than 102,000 of these children have been enrolled since the expansion in September 2008. Today, New York provides health care coverage to 2.1 million children. Slightly more than 1.7 million children are covered by Medicaid and another 390,000 by Child Health Plus. This represents more than 40 percent of the state's children.

The number of uninsured children in New York continues to decline. The number of uninsured children under the age of 19 in New York State decreased from 395,000 in 2007 to 310,000 in 2008. This decline is directly attributable to increased access to insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Children ages 1-5 years of age are eligible for Medicaid at 133% of the FPL for twelve months of continuous coverage, even if their family's income exceeded eligibility levels during that year. Children ages 6-19 at 100% FPL			X	X
2. Infants are eligible at or below 200% of poverty. All infants born to women enrolled in Medicaid are MA-eligible the end of their month of their first birthday.			X	X
3. Facilitated enrollers are available statewide to assist families with public insurance enrollment processes. All MCHSBG funded programs are required to facilitate enrollment in insurance.		X	X	X
4. Families at or below 400% of the Federal Poverty Level are eligible for Child Health Plus (New York's State Child Health			X	X

Insurance Program). Families over 400% of FPL are eligible for participation at full premium.				
5. Comprehensive Prenatal/Perinatal Services Networks facilitate the implementation of Medicaid Managed Care within their catchments area. Many Networks are facilitated enrollers for health insurance programs.			X	X
6. Children with Traumatic Brain Injury injured before the age of 18 are eligible for Medicaid under a special waiver.			X	X
7. CSHCN who do not have a source of insurance are assisted by the CSHCN Program to enroll in an insurance program.		X	X	X
8. The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance. Success rates are tracked.		X		
9. The insurance status for all students enrolled in SBHCs is determined as part of the initial enrollment process and a facilitated enroller works with students/parents/guardians with no insurance to connect them to Child Health Plus and Medicaid.		X		X
10.				

b. Current Activities

-In 2009, NY expanded access to health care for children. Medicaid coverage is now automatically extended for all 18-20 year olds leaving foster care until their 21st birthday. The CHP program expanded access to critical services by implementing mental health parity.
-NY received federal approval for the CHP expansion that provides federal matching funds for the expansion back to September 2008, and included two new exceptions to the six month waiting period. No child under the age of five or any child whose family must contribute more than 5 percent of their income to purchase employer sponsored health insurance will be subject to the waiting period.
-NY has made it easier to apply for coverage, and launched a statewide outreach campaign, Connections to Coverage, to promote the availability of public health insurance coverage for all children and eligible adults.
-All MCHSBG-funded programs are required to facilitate enrollment in insurance. CSHCNs without insurance are linked to insurance by the CSHCN program.
-CPPSNs facilitate the implementation of Medicaid Managed Care within their catchment areas, with many serving as facilitated enrollers. They provide outreach, information and education regarding all public health insurance programs.
-School-Based Health Centers address gaps in the health care system by eliminating barriers that may prevent youth from receiving needed health care. Those without insurance are connected to facilitated enrollers.

c. Plan for the Coming Year

New York will continue to promote and simplify New York's public health insurance programs for children and families. Through the Maximizing Enrollment for Kids grant awarded to New York by the Robert Wood Johnson Foundation, the Department will explore the potential to enroll even more children in coverage through the use of express lane eligibility which will significantly simplify the enrollment process for families.

New York will also launch a public health insurance eligibility screening tool as well as other consumer assistance tools that will make it easier for families to apply for coverage.

In 2010, the State will further simplify public coverage through the elimination of the face to face interview requirement for Medicaid.

New York will continue to partner with community-based organizations, faith groups, schools,

health and human service providers and others across the state to link uninsured children and families to facilitated enrollment in their communities, and plans to implement a "Connections to Coverage" campaign to create increased awareness of the availability of insurance. MCHSBG funded programs will also continue to link children and families to facilitated enrollers to increase the number of children with coverage.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	31	30	29
Annual Indicator	32.1	32.0	32.0	32.0	32.0
Numerator	24562	63874	63373	67108	67108
Denominator	76566	199608	198041	209713	209713
Data Source				PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29	28	28	28	27

Notes - 2009
2008 data are being used as a proxy for 2009.

Notes - 2007
2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
Effective January 1, 2009, New York was the first state in the nation to implement the new WIC food package, including fruits and vegetables, whole grain cereals and breads, brown rice, tofu, canned and dried beans, reduced juice amounts, and low-fat milk for all participants over the age of two years. The WIC Program provided training to over 200 WIC neighborhood vendors to assure that the healthier food options promoted through WIC were available to participants.

Breastfeeding has been identified as a core strategy for obesity prevention. The NYS WIC Program expanded its successful Breastfeeding Peer Counselor Program, with the goal of achieving a program in all 100 WIC local agencies by 2010. A Department of Health Breastfeeding Workgroup, with department-wide representation was established in 2009. The focus of the workgroup is support for breastfeeding in hospitals and worksites. Monitoring of hospital specific breastfeeding data has begun. Department of Labor worksite guidelines for breastfeeding support were distributed to over 500 individuals including worksite contractors. Ten "Business Case for Breastfeeding" trainings, sponsored by NYSDOH and the NY Statewide Breastfeeding Coalition were provided to contractors. The Child and Adult Care Food Program (CACFP) successfully implemented a Breastfeeding Friendly Initiative, recognizing child care centers and family day care homes that provide an atmosphere that welcomes breastfeeding families, help mothers continue to breastfeed when they return to work or school, feed infants on demand, train all staff to support breastfeeding families, and create a written breastfeeding

support policy. (Refer to NPM #11 for further details.)

Several initiatives targeted children, their families and the staff in child care settings. CACFP established new Healthy Child Meal Patterns for child care centers and day care homes participating in CACFP, affecting more than 9,100 family day care homes and 4,000 day care centers serving 290,000 New Yorkers. The new Healthy Child Meal Pattern improves meals served to young children by increasing whole grains, limiting juice, offering only unflavored low-fat milk over age 2, and promoting a variety of fruits and vegetables.

CACFP implemented the Eat Well Play Hard in Child Care Settings (EWPHCCS) intervention, designed to improve the nutrition and physical activity behaviors of pre-school age children, and their parents /caregivers and influence food and activity practices in child care settings, in 253 low-income CACFP-participating centers last year. EWPHCCS nutritionists reached nearly 13,000 pre-school age children, family members, and child care center staff with lessons on healthy eating and being more physically active. The Center of Excellence for Training and Research Translation (Center TRT) at the University of North Carolina recently posted the EWPHCCS intervention for national dissemination.

The Department's Obesity Prevention Program coordinated the implementation of the NAP SACC (Nutrition and Physical Activity Assessment for Child Care) intervention in 20 counties in the state. The NAP SACC intervention strives to improve nutrition, physical activity and TV viewing policies, practices and environments in child care centers. NAP SACC activities were accomplished through a variety of contractors including the NYS Child Care Coordinating Council, Eat Well Play Hard Community Projects, and Eat Well Play Hard in Child Care Settings participating child care centers. The NAP SACC intervention was initiated, partially completed or completed in 45 child care centers representing 791 staff, and reaching 4,243 children. In the 31 centers that completed the intervention, 463 staff were trained and 2,501 children were reached.

During 2009, the Eat Well Play Hard Community Projects facilitated the implementation of more than 300 environmental and systems changes in targeted settings across 22 counties in New York State. Examples include assisting school and district wellness committees around the state in implementation of policies that support healthy snacks, consistent food standards across the school campus, and increased physical activity opportunities; increased the number of schools and day care centers that have switched to low-fat milk and incorporated other healthier menu options; and implemented new farmers' markets in low-income communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A new WIC food package was implemented which included fruits and vegetables, whole grain cereals and breads, brown rice, tofu, canned and dried beans, reduced juice amounts, and low-fat milk for all participants over the age of two years.			X	
2. DOH implemented Healthy Child Meal Patterns for child care centers and day care homes participating in CACFP, affecting more than 9,100 family day care homes and 4,000 day care centers serving 290,000 New Yorkers.			X	
3. DOH continues implementation of the Eat Well Play Hard in Child Care Settings (EWPHCCS) intervention, designed to improve the nutrition and physical activity behaviors of pre-school age children and influence food and activity practices in child care		X	X	
4. The Department’s Obesity Prevention Program coordinated the implementation of the NAP SACC (Nutrition and Physical		X		X

Activity Assessment for Child Care) intervention in 20 counties in the state.				
5. The Eat Well Play Hard Community Projects facilitated the implementation of more than 300 environmental and systems changes in targeted settings across 22 counties in New York State				X
6. DOH continues implementation of the Eat Well Play Hard in Child Care Settings (EWPHCCS) intervention, designed to improve the nutrition and physical activity behaviors of pre-school age children and influence food and activity practices in child care			X	
7. Childhood obesity prevention activities will continue to be implemented to prevent obesity through sustainable policy, systems and environmental changes in communities.		X	X	X
8.				
9.				
10.				

b. Current Activities

PedNSS data continues to be collected and analyzed. The Obesity Prevention Program is expanding surveillance and evaluation efforts to include TV viewing, breastfeeding supports and policies in worksites and maternity care practice facilities. Collection of overweight and obesity data (BMI) on Kindergarten, school age and high-school age children in NYS selected school districts continues.

To enhance current efforts to reduce overweight/obesity, the NYS WIC Program is implementing consistent core services at all agencies, including: Breastfeeding Peer Counselor Programs, Participant-Centered Nutrition Education, Facilitated Group Discussions called Talk, Listen, Connect (TLC), and Healthy Lifestyles. CACFP is training participating child care centers and homes on the new Healthy Child Meal Pattern, and expanding the Eat Well Play Hard in Child Care Settings intervention to 300 more child care centers. The Hunger Prevention and Nutrition Assistance Program is expanding access to fresh produce, low-fat dairy products and whole grains for families who access emergency food services.

The Obesity Prevention Program continues work with partners to: establish policy and environmental supports for breastfeeding; focus on local and state-level interventions to increase the consumption of fruits and vegetables, decrease the consumption of sugar-sweetened beverages and high energy dense foods; and promote physical activity through environmental and policy changes.

c. Plan for the Coming Year

Childhood obesity prevention activities will continue to be implemented through numerous avenues including: child nutrition programming, statewide coalitions, community-based contracts, statewide and local policy efforts, partnerships with health care and collaboration with state and federal partners. Plans for the coming year include:

o Strengthen policies and environments that promote and support breastfeeding.

o Increase screening and early recognition of overweight and obesity by pediatric healthcare providers.

o Provide local, county and statewide estimates of the prevalence of childhood obesity.

o Target resources to populations most at risk for childhood obesity.

o Identify best practices and promising interventions in child care, schools and communities to help prevent and reduce childhood obesity.

o Through a collaborative effort between the Division of Nutrition and the Division of Chronis Disease and Injury Prevention, implement 20 grant-funded projects to prevent obesity

through sustainable policy, systems and environmental changes in communities.
o Expand Eat Well Play Hard in Child Care Settings to family day care homes.
o Provide education, technical assistance and support in the development and advancement of legislation promoting access to healthier food and beverage options and increased opportunities for physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15	14	14	13
Annual Indicator	15	12.2	13.7	11.9	11.9
Numerator					
Denominator					
Data Source				PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	11	11	11	10

Notes - 2009
2008 NYS PRAMS data, exclusive of NYC, are being used as a proxy for 2009. Numerator and denominator data are not available (survey data).

Notes - 2008
Data from 2008PRAMS - NYS exclusive of NYC data. Numerator and denominator data are not available (survey data).

Notes - 2007
2006 NYS PRAMS data, exclusive of NYC, are being used as a proxy for 2007.

a. Last Year's Accomplishments
Efforts to reduce smoking in pregnant women are a part of the Department's multi-pronged efforts to reduce smoking in the general public. These efforts include a coordinated set of evidence-based activities implemented primarily by the tobacco control program, in partnership with other public health programs, including Title V programs, and other external partners:
- Community Partnerships work to change the community environment to support the tobacco free norm.
Youth Action partners work with youth activists to change community norms and de-glamorize and de-normalize tobacco use.

Cessation Centers work with health care organizations and providers to implement systems to screen patients for tobacco use and provide help.

Statewide media and counter marketing educate New Yorkers about the health risks of tobacco use and the dangers of second hand smoke, motivating tobacco users to stop, and promoting use

of the NYS Smokers' Quitline and Quitsite (1-866-NY-QUITS, www.nysmokefree.com). Specific educational materials for pregnant women.

Counter-marketing efforts seek to expose marketing practices of the tobacco industry, de-glamorize tobacco use, and build and sustain a tobacco-free norm.

Medicaid prenatal care providers promote healthy behaviors during pregnancy. Prenatal care providers provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation. Medicaid covers smoking cessation products and programs.

School-Based Health Centers screen for tobacco use and make appropriate referrals to obstetrical services and smoking cessation programs, and counsel students accordingly.

The Comprehensive Prenatal-Perinatal Services Networks' priorities include developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy. Networks provide education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.

The Community Health Worker Program provides education for pregnant and postpartum women to increase their understanding of behaviors that pose a risk to health, including the use of tobacco, and provision of appropriate referrals for those women seeking assistance in this area, including accompanying them to care, if necessary.

Family Planning Programs screen for tobacco use and refer for smoking cessation.

All Migrant and Seasonal Farm Worker Health programs and American Indian Health Program providers screen for tobacco use and make appropriate referrals.

School-based dental health center staff screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.

New York State continued to enforce the Clean Indoor Air Act.

All WIC local agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Prenatal care providers provide information on the impact of smoking on the woman and the fetus and developed programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.		X	X	
2. The Comprehensive Prenatal-Perinatal Services provide education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.			X	
3. The Community Health Worker Program provides education for pregnant and postpartum women to increase their understanding of behaviors that pose a risk to health, including the use of tobacco, and provision of appropriate referrals.			X	

4. Migrant and Seasonal Farm Worker Health programs and American Indian Health Program providers screen for tobacco use and make appropriate referrals.	X	X	X	
5. School-based dental health center staff screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.	X			
6. WIC local agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco.	X	X		
7.				
8.				
9.				
10.				

b. Current Activities
Continued multi-pronged activities described above.

Tobacco Control Program contracts with an independent evaluator to evaluate programmatic efforts.

Continue education and outreach activities to prenatal care providers on changes to Medicaid reimbursement for smoking counseling for pregnant women and broader changes to Medicaid Prenatal Care Standards and APG-based reimbursement (see HSCI #04, #05). Effective January 1, 2010, Medicaid covers smoking cessation counseling for pregnant and postpartum women and adolescents to age 21. Smoking cessation counseling complements existing Medicaid covered benefits for prescription and non-prescription smoking cessation products.

c. Plan for the Coming Year
Continue multi-pronged activities described above.

Continue promoting the availability of Medicaid reimbursement to ensure that as many pregnant women as possible who use tobacco receive counseling and associated services.

The Tobacco Control program is planning a media campaign entitled "Premiee" showing the effects of smoking on pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.2	4.1	4.1	4	3.8
Annual Indicator	3.9	3.7	3.9	3.3	3.3
Numerator	52	51	54	46	46
Denominator	1318372	1385081	1396874	1403050	1403050
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.8	3.7	3.7	3.6	3.5

Notes - 2009
2008 data are being used as a proxy for 2009

Notes - 2007
.

a. Last Year's Accomplishments
Bureau of Injury Prevention and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning. The Bureau of Injury Prevention developed fact sheets with relevant data and best practice strategies for reducing the risk of self-inflicted injury and death. The fact sheets are part of a series child injury prevention fact sheets for medical providers, researchers, educators and consumers.

The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials.

OMH funds community mental health services that include suicide prevention and crisis hotlines.

Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance Abuse Services (OASAS) continued to make available their campaign entitled, "Underage drinking: Not a minor problem." The package includes fact sheets and resource directories. MCHSBG Advisory Council members were also presented with this package. Title V programs have access to the campaign and associated materials.

The School-Based Health Center (SBHC) Program includes an evaluation for suicide risk as a part of the initial health assessment and whenever indicated, crisis intervention visits. Mental health services, including crisis intervention, were available through the school-based health center or by referral. Referrals are also made for more intensive consultation or treatment. School staff, family members and other students are also offered consultation and education. Approximately 25% of SBHC visits indicated emotional problems as a primary reason for the visit.

An Office of Mental Health initiative continued to operate expanded school-based mental health services in five schools. This initiative provides a range of psychological support, education, consultation and treatment for students and families, co-located with a comprehensive school-based health center. School staff education and support were also an integral component of the model.

Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities for youth as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence abuse and risky sexual behaviors, as well as peer education materials, conflict resolution training to train peer mediators, and mentoring programs.

NYS continued implementation of the Lesbian, Gay, Bisexual and Transgendered Health Initiative. Over half of the grantees under this initiative are focused on issues related to gay and

lesbian youth and issues with alcohol, substance abuse and self-inflicted injuries. Data from other states indicate that gay, lesbian and bisexual youth are approximately 4 times more likely to attempt suicide than their heterosexual counterparts.

The Sexual Violence Primary Prevention Committee (SVPPC), as part of the needs assessment being conducted, is looking at data associated with other forms of violence as risk factors for victimization or perpetration of sexual violence. Studies also show that over one half of rapes and sexual assaults occur to women between the ages of 12 and 24. Although it is difficult to document the true prevalence of sexual violence, studies indicate that 1 in 6 of adult females and 1 in 33 of adult males have been victims of rape or attempted rape. More than half of all rapes of females occurred to women younger than 18; 22 percent occurred to females younger than 12. In approximately 8 out of 10 cases (83 percent) the victim knew the perpetrator. Victims of sexual violence are left with emotional scars such as fear, anger and anxiety which can lead to depression or suicide attempts. The Department continues to fund a statewide network of rape crisis programs for the provision of services to victims of rape and for the development and implementation of sexual violence primary prevention initiatives.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Bureau of Injury Prevention and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.			X	X
2. The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials.			X	X
3. Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance Abuse Services (OASAS) continued to make available their campaign entitled, “Underage drinking: Not a minor problem.”			X	X
4. OMH continued to operate an expanded school-based mental health initiative in 5 schools. This initiative co-located a comprehensive mental health services clinic with school-based health centers.	X	X	X	
5. Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence/abuse.			X	X
6. NYS continued implementation of the Lesbian, Gay, Bisexual and Transgendered Health Initiative.			X	X
7. There is continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services.				X
8. The SVPPC will continue implementation activities to stop sexual violence before it occurs.		X	X	X
9.				
10.				

b. Current Activities

There have been no major changes in programming. Title V will continue to collaborate with partners in suicide prevention. The Bureau of Injury Prevention completed development of fact

sheets to provide up to date data, best practices and evidence-informed programs to reduce self-inflicted injuries for medical providers, researchers, educators and consumers. The fact sheets will be posted on the department website and available in hard copy upon request.

c. Plan for the Coming Year
The Division of Family Health will continue to collaborate with the Bureau of Chronic Disease and Injury Prevention, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services in activities to prevent suicide.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	91	92	92	94
Annual Indicator	87.1	88.6	89.7	90.0	90.0
Numerator	3281	3345	3252	3281	3281
Denominator	3765	3774	3627	3646	3646
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94	95	95	95	95

Notes - 2009
2008 data are being used as a proxy for 2009.

Notes - 2008
2007 data are being used as a proxy for 2008.

Notes - 2007
2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
New York State's has been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the Department as a Level I, II, II or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns. While RPCs and Level III hospitals accounted for 64 percent of all births in 2008, approximately 90 percent of all very low birth weight (VLBW) infants were delivered at RPC and Level III facilities. Conversely, less than 10 percent of VLBW infants were delivered at Level I and II hospitals, which accounted for approximately 36 percent of all newborn deliveries in the state in 2008. The trend towards delivery of high-risk newborns at appropriate level hospitals suggests the effectiveness of perinatal regionalization. The Statewide Perinatal Data System also captures data why VLBW infants were born at lower level hospitals and the majority are due unavoidable events, such as

inability to transfer the woman to a higher level hospital due to advanced stage of labor.

A range of public health initiatives including the system of perinatal regionalization, efforts to increase access to early and continuous prenatal care, community-based programs that target high-risk areas to identify and address gaps in needed services, and home visiting programs, such as the Nurse Family Partnership, Healthy Families New York and the Community Health Worker Program, have all been critical in achieving these improvements. These efforts have effectively combined medical and community-based interventions to improve perinatal outcomes in New York State.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented public health initiatives, including the system of perinatal regionalization, to increase access to early and continuous prenatal care, targeting high-risk areas to identify and address gaps in needed services and improve perinatal outcom		X		X
2. Quality assurance visits are conducted to affiliate hospitals to improve perinatal quality and outcomes, including review of complex cases and whether cases should have been transferred to regional centers.		X		
3. Continue to collaborate with the RPCs and the National Initiative for Children's Healthcare Quality (NICHQ) and an external expert advisory group to implement interventions designed to improve perinatal outcomes.				X
4. The Division of Family Health will continue to partner with the Office of Health Insurance Programs in implementation of Medicaid Prenatal Care and the Healthy Mom-Healthy Baby (HM-HB) home visiting programs.			X	X
5. Pilot the use of the Prenatal Care Risk Screening form for early identification of risk status to Medicaid managed care plans, ensuring systems of perinatal care for assessment and referral of high-risk women to appropriate level of services.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Regional Perinatal Centers (RPCs) remain the core component of the perinatal regionalization system. Affiliation agreements among hospitals guide maternal and infant consultation and transfers.

RPC staff conduct quality assurance visits to affiliate hospitals and work with them to improve perinatal quality and outcomes, including review of complex cases and whether cases should have been transferred. RPCs also conduct educational programs on-site at affiliates and through grand rounds presentations on programs such as stabilization of VLBW and ELBW infants in preparation for transfer, to prepare affiliates for emergency cases.

The Department has an oversight role to identify and address appropriateness of care issues that may occur, in ensuring moderate to high-risk pregnant women, fetuses and newborns continue to receive care at the appropriate perinatal level, and that perinatal networks function properly with

RPCs providing oversight of affiliates within their network.

The Department is currently working with RPCs and the National Initiative for Children's Healthcare Quality (NICHQ) and an external expert advisory group to develop and implement obstetric and neonatal interventions designed to improve specifically identified perinatal outcomes. In consultation with RPCs, the Department will begin implementation of an obstetric intervention to reduce scheduled near term deliveries (36-38 weeks) without indication later this year.

c. Plan for the Coming Year
Continue to work closely with the RPCs and affiliate hospitals to monitor and support effective use of the established system of perinatal regionalization

Continue to collaborate with the RPCs and the National Initiative for Children's Healthcare Quality (NICHQ) and an external expert advisory group to implement selected obstetric and neonatal interventions designed to improve perinatal outcomes, including the current obstetric intervention to reduce scheduled deliveries prior to 39 weeks without medical indication.

Maintain efforts related to access to prenatal care services and community-based initiatives designed to identify and engage pregnant women in early and continuous prenatal care.

The Division of Family Health will continue to partner with the Office of Health Insurance Programs in implementation of Medicaid Prenatal Care and the Healthy Mom-Healthy Baby (HM-HB) home visiting programs. HM-HB programs will pilot the use of the Prenatal Care Risk Screening form for early identification and communication of risk status to Medicaid managed care plans. These programs will also work to ensure the development of countywide systems of perinatal care and the assessment and referral of high-risk women to appropriate level of services.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	77	78	79	80
Annual Indicator	75.4	74.6	73.8	72.3	72.3
Numerator	174737	174078	174949	165813	165813
Denominator	231661	233441	236903	229467	229467
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	81	82	82	82	82

Notes - 2009
2008 data are being used as a proxy for 2009.
Denominator excludes births where trimester when prenatal care began is unknown

Notes - 2008
Denominator excludes births where trimester when prenatal care began is unknown.

Notes - 2007
Denominator excludes births where trimester when prenatal care began is unknown

a. Last Year's Accomplishments
NYS's perinatal programs employ a comprehensive, multi-level strategy, which integrates broad based systems approaches involving regional and local planning; one-on-one outreach and support through home visiting programs to assess and address the perinatal health needs of residents in high risk communities; population-based education, media and informational resources; public health insurance and clinical practice standards and collaborations; and extensive surveillance work to support public health planning and clinical quality improvement efforts.
-DOH's Growing Up Healthy Hotline (GUHH), available 24/7, provides information and referral in English and Spanish and in other languages via the AT&T language line. The GUHH number is used in media campaigns to promote early and continuous access to prenatal care and other services. In 2009, GUHH responded to 61,518 calls including 7,918 phone calls requesting referral and information related to pregnancy testing and/or prenatal care.
-The statewide network of DOH-supported Comprehensive Prenatal Perinatal Services Networks (CPPSNs) have local toll-free numbers, web sites, and resource directories to provide pregnant women with information and referral to prenatal care. CPPSNs identify gaps and barriers to the service system, and in collaboration with the community stakeholders, work to increase accessibility and the quality of the local perinatal service system. Networks co-chair regional perinatal forums in collaboration with Regional Perinatal Centers (RPCs), which combine community-based and clinical perspectives to prioritize and address regional MCH issues such as access to prenatal care, breastfeeding and other priority MCH issues.
-Medicaid prenatal care providers encouraged early enrollment in prenatal care, and provided presumptive Medicaid eligibility to ensure that women were able to begin prenatal care immediately pending determination of Medicaid eligibility.
-The Community Action for Prenatal Care (CAPC) Program, a collaboration between Title V and the AIDS Institute, continued. CAPC seeks to decrease negative birth outcomes, including perinatal HIV transmission, by conducting street outreach and referral to high risk communities to engage high risk, substance using pregnant women into prenatal care.
-DOH continued to support 23 Community Health Worker Programs (CHWPs) statewide. CHWPs conduct outreach to engage pregnant women into prenatal care and ensure the family has access to other services. CHWs are indigenous to the communities they serve. They help women access prenatal care and provide education, referrals and follow-up through monthly home visits. The CHWP served 3,211 families, including 1,416 women, 2,120 infants and 1,416 children. Of those women who were not already in prenatal care, 96% were assisted to receive prenatal care within 1 month of entry to the program. Of the total number of pregnant women, 80.2% entered prenatal care in the first trimester, 16.6% in second, 2.2% in third; only 0.74% did not receive prenatal care.
-School--based health centers provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to the back-up facility.
-The Family Planning Programs made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served.
-The Title V Program collaborated with Medicaid to develop updated prenatal standards for all pregnant women enrolled in Medicaid. In addition, new legislation was enacted to address the impact of the new Ambulatory Patient Group (APG) payment methodology on Medicaid

reimbursement for prenatal care services; eliminate PCAP designation, certification, and associated rates; and ensure a comprehensive, high quality model of care for all pregnant women who qualify for Medicaid. The legislation also required that all Medicaid enrolled Article 28 prenatal care providers perform presumptive eligibility determinations and assist with completion of the full Medicaid application and Medicaid managed care plan selection. All prenatal care providers must provide prenatal care services to pregnant women determined presumptively eligible for Medicaid but not yet enrolled.
-The Department holds periodic meetings and/or conference calls with Healthy Start grantees in order to foster better communication and explore areas for potential collaboration.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The GUHH, available 24/7, provides information and referral in multiple languages via the AT&T language line. The number is used in media campaigns to promote early and continuous access to prenatal care and other services.			X	
2. The statewide network of DOH-supported CPPSNs have local toll-free numbers, web sites, and resource directories to provide pregnant women with information and referral to prenatal care.			X	
3. Medicaid prenatal care providers encouraged early enrollment in prenatal care, and provided presumptive Medicaid eligibility to ensure that women were able to begin prenatal care immediately pending determination of Medicaid eligibility.	X			
4. 4. CHWPs conduct outreach to engage pregnant women into prenatal care and ensure family access to services. CHWs are indigenous to the communities they serve and provide education, referrals and follow-up through home visits.		X	X	
5. School–based health centers provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to the back-up facility.	X			
6. The Family Planning Programs made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served.	X			
7. The Title V Program collaborated with Medicaid to develop updated prenatal standards for all pregnant women enrolled in Medicaid to ensure a comprehensive, high quality model of care for all pregnant women who qualify for Medicaid.		X		
8. Through collaboration with the Office of Temporary and Disability Assistance, three certified Nurse Family Partnership (NFP) programs deliver home visiting services to pregnant women with incomes up to 200% FPL.		X		
9. Outreach efforts conducted through the CHWP and consumer awareness strategies implemented through the CPPSN programs will continue with a central focus on identifying and engaging women to seek early and continuous prenatal care.		X		
10.				

b. Current Activities
-The updated Medicaid prenatal standards became effective November 2009. Standards include evidence-based practices that integrate updated standards and guidance from ACOG and AAP and reflect expert consensus on appropriate care for high-risk pregnant women. The Title V program is working with the DOH Office of Health Insurance programs to facilitate transition from

PCAP to implement these standards statewide.
-DOH continues to support the Growing Up Healthy Hotline.
-DOH continues to support the CPPSNs and CHWPs. A RFA for the next 5-year funding cycle for these programs is under development.
-New state funding allowed DOH to support a Healthy Mom-Healthy Baby program in six counties with at least 50,000 females ages 15-44 years, high rates of low birth weight, adolescent pregnancy and births, and neonatal intensive care unit admissions for Medicaid clients. Local health departments are funded to engage key stakeholders plan and implement countywide systems of care.
-Through collaboration with the Office of Temporary and Disability Assistance, funds to support the three certified Nurse Family Partnership (NFP) programs in the state to deliver home visiting services to pregnant women with incomes up to 200% FPL were allocated to DOH through a MOU.
-A targeted media campaign to promote early prenatal care and the availability of Medicaid prenatal care services in high-risk communities is planned to launch later this year.

c. Plan for the Coming Year
-Outreach efforts conducted through the Community Health Worker program, and consumer awareness strategies implemented through the Comprehensive Prenatal/Perinatal Service Network programs will continue with a central focus on identifying and engaging women to seek early and continuous prenatal care. A new five-year funding cycle for both programs will begin in July 2011.
-A web-based training module for CHW workers is being developed. This module will provide community health workers with access to information on maternal and child health topics such as the importance of prenatal care visits, the stages of pregnancy, staying healthy during pregnancy, preparing for birth and homecoming, and the role of the father in pregnancy and birth. The module will allow new community health workers to gain knowledge critical to their roles, and it will provide a resource to those in need of a refresher course.

D. State Performance Measures

State Performance Measure 1: *Percent of Live Births Resulting from Unintended Pregnancies*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32.8	32.7	31	31
Annual Indicator	35.8	33.4	37.5	29.6	29.6
Numerator					
Denominator					
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30.5	30	29.5	29	

Notes - 2009
2008 data are being used as a proxy for 2009. Numerator and denominator data are not available. Data are from the NYS PRAMS survey for areas in NYS outside of NYC.

Notes - 2008

Numerator and denominator data are not available. Data are from the NYS PRAMS survey for areas in NYS outside of NYC.

Notes - 2007
Numerator and denominator data are not available. Data are from the NYS PRAMS survey for areas in NYS outside of NYC.

a. Last Year's Accomplishments
-NYS Family Planning Program (FPP) provided comprehensive reproductive health services following federal Title X guidelines to over 343,000 individuals for a total of over 605,000 visits. The FPP continues to target outreach to minorities and individuals under 150% of the Federal Poverty Level (FPL).
-Supported by a MA waiver, the Family Planning Benefit Program (FPBP) provides Medicaid (MA) coverage for FP services for women and men with incomes less that 200% of the FPL. The Family Planning Extension Program (FPEP) provides MA benefits to eligible women for 24 months after a pregnancy ends. NY implemented additional MA reimbursement for more costly methods Implanon and IUDs for clients covered by MA, FPBP and FPEP.
-Enhanced services/initiatives supported by state and/or federal funds included: free emergency contraception; screening for breast and cervical cancer; STD screening and treatment; HPV vaccinations; HIV counseling and testing; Male Services grants to increase services to adolescents; projects in two female correctional facilities for reproductive health education and clinical services to inmates to be released from incarceration; projects to provide services to adolescent males and immigrant women; and one mobile van rural initiative.
-FPPs provided almost 8,000 community education and training sessions attended by over 94,000 participants
-Community Health Worker Program provided family planning information, referral and follow-up to women of childbearing age. See NPM #18 and HSCI #04, 05
-Adolescent Pregnancy Prevention and Services (APPS) Program worked to reduce teen pregnancies in high risk zip codes and provided services to high risk youth. See NPM #08 and SPM#04.
-Community Based Adolescent Pregnancy Prevention (CBAPP) Programs worked to reduce teen pregnancies in the highest risk zip codes across NYS. Redirection of state funds formerly used for Abstinence-only education programs, supported enhancement/expansion of CBAPP. See NPM #08 and SPM#04 .
-Continued to support the ACT for Youth Center of Excellence (ACT COE) to provide training, technical assistance and consultation to DOH and adolescent health providers statewide.
-An intradepartmental Adolescent Sexual Health Work Group (ASHWG) works to coordinate and collaborate activities and information across DOH programs to advance adolescent sexual health priorities and strategies.
-In collaboration with the ACT COE, an adolescent sexual health symposium was convened with expert researchers and stakeholders to inform public health programs and policies.
-School--based health centers (SBHCs) provided risk assessment, anticipatory guidance and health education for sexual activity as part of the initial assessment and annual comprehensive physical examination, and pregnancy testing where indicated. Students have access to family planning services or prenatal services onsite or by referral. SBHCs provided services to approximately 33,000 female students ages 15-19.
-Comprehensive Prenatal-Perinatal Services Networks (CPPSN) provided family planning information and education on the importance of interconceptional care. See NPM #08 and SPM#04.
-A law requiring hospitals to provide information and dispense emergency contraception (EC) to survivors of sexual assault was implemented. An EC brochure is available in seven languages and on the DOH website. Hospitals and other sites are directly compensated for forensic exams.
-A preconception care packet, including Components of Preconception Care checklist and Preconception Care Guide for Optimizing Pregnancy Outcomes, was developed in collaboration with the American Congress of Obstetricians and Gynecologists NY, Region II, and distributed to over 16,000 obstetricians/gynecologists, nurse practitioners, and pediatricians specializing in

adolescent health. The materials are designed to encourage medical professionals to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Program provided comprehensive reproductive health services and outreach following Federal Title X guidelines to over 343,000 individuals for a total of over 605,000 visits to individuals and minorities under 150% of FPL.	X			
2. Community Health Worker Program provided family planning information, referral and follow-up to women of childbearing age.		X		
3. Adolescent Pregnancy Prevention and Services (APPS) Program worked to reduce teen pregnancies in high risk zip codes and provided services to high risk youth.	X		X	
4. Community Based Adolescent Pregnancy Prevention (CBAPP) Programs worked to reduce teen pregnancies in the highest risk zip codes across NYS.			X	
5. School–based health centers provided risk assessment, anticipatory guidance and health education and pregnancy testing to approximately 33,000 female students ages 15-19. Students have access to family planning services onsite or by referral.	X			
6. Comprehensive Prenatal-Perinatal Services Networks (CPPSN) provided family planning information and education on the importance of interconceptional care.		X		
7. The ACT for Youth Center of Excellence began monthly webinars with CBAPP and APPS providers on topics including male involvement in pregnancy prevention, unique needs of youth in foster care, and gang involvement.			X	X
8. DOH launched a media campaign that includes sexual health promotion messages on teen pregnancy, STD and HIV with a call to action to a new youth-friendly web site			X	
9. Preconception Health Café, a web-based course to teaches paraprofessionals about the importance of preconception health and provides tips to maximize opportunities to discuss preconception health with women.			X	
10. The Comprehensive Adolescent Pregnancy Prevention Program implemented evidence-based programming and increased access to reproductive health services in communities with the highest burden of teen pregnancy, births and STD's.			X	

b. Current Activities

-Previous activities continue.

-A Request for Applications (RFA) is being finalized for new 5 year cycle for FPP to provide comprehensive family planning and reproductive health services statewide.

-The ACT for Youth Center of Excellence began monthly webinars with CBAPP and APPS providers on topics including male involvement in pregnancy prevention, unique needs of youth in foster care, and gang involvement.

-An RFA is under development to integrate current CBAPP and APPS programs in a single Comprehensive Adolescent Pregnancy Prevention (CAPP) initiative to begin 1/1/11, with an emphasis on evidence-based sexuality education programming in schools and other community

settings, access to reproductive health services, multi-dimensional life skills development, and community collaboration.
-DOH launched a media campaign that includes sexual health promotion messages on teen pregnancy, STD and HIV with a call to action to a new youth-friendly web site at www.nysyouth.net .
-The Sexual Violence Primary Prevention Committee will continue to meet to refine and evaluation the Sexual Violence Prevention Plan.
-The Department funded development of the Preconception Health Café, http://www.albany.edu/sph/coned/women.htm, a web-based course to teach paraprofessionals about the importance of preconception health and provide tips to maximize opportunities to discuss preconception health with women.

c. Plan for the Coming Year
-Continue ongoing activities and services.
-A new 5-year funding cycle for the state Family Planning Program will begin January 2011. A new Family Planning and Reproductive Health Care Program Center of Excellence will be funded to provide technical assistance, evaluation, training and serve as a clearing house for resources and best practices to Department and the network of family planning providers to assure the provision of consistent, high quality services. Quality improvement measures, benchmarks and activities will be strengthened across the program.
-A 5-year cycle for the new CAPP initiative will begin January 2011, with continued support from ACT COE. Funding will target the areas of the state with the highest burden of teen pregnancy and births, STDs and other individual, family and community factors that contribute to poor adolescent sexual health outcomes. Programs will be required to implement evidence-based programming, increase access to reproductive health services, support life skill development, and collaborate with other community organizations to support adolescent development.
-The SBHC program plans to incorporate reporting on provision of age-appropriate Reproductive Health screening as a required indicator on the program's reporting tool, and expand the measures associated with it.
-New York will continue to utilize the website developed for the Adolescent Sexual Health Media Campaign (www.nysyouth.net) to provide continually updated health information for youth.
-Community Health Worker Program staff will complete the Preconception Health Café web module as part of their training requirements. The web module will be promoted to internal and external partners.

State Performance Measure 2: *Hospitalization Rate for Asthma in Children 1 to Age 14*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		245	235	235	235
Annual Indicator	335.9	346.5	320.5	328.7	328.7
Numerator	11729	11968	10738	11024	11024
Denominator	3492321	3453631	3350465	3353858	3353858
Data Source				SPARCS	SPARCS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	230	230	230	220	

Notes - 2009
2008 data are being used as a proxy for 2009

Notes - 2008

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a. Last Year's Accomplishments

- An advisory workgroup was established as a sub-committee of the Asthma Partnership of New York (APNY) to develop and implement a statewide strategy to promote asthma self-management support services for Medicaid beneficiaries and their families diagnosed with asthma. The goal of this workgroup is to increase the number of certified asthma educators (AE-Cs) in New York State and improve their integration into clinical practice so as to increase New Yorkers' access to asthma self-management support services.
- A second advisory workgroup was established as a second subcommittee of the APNY to develop an asthma self-management toolkit for New Yorkers with asthma and their families. The goal of the workgroup is to assure that NYS residents with asthma will have access to accurate, culturally and linguistically appropriate asthma educational materials to assist them in controlling their asthma. The NYS Asthma Self Management Toolkit will translate the statewide guideline into actionable steps for consumers to gain control of their asthma.
- New York State Consensus Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma- 2008 (Booklet) was developed by the NYS Consensus Asthma Guideline Expert Panel for primary care providers, and endorsed by the State and NYC health departments, as well as numerous professional societies and groups. The booklets were mailed to over 23,000 New York State providers. Since the mailing, an additional 3,184 booklets were distributed by request from the New York State Department of Health distribution center and the electronic version of the booklet received approximately 1,550 page views on line at http://www.health.state.ny.us/diseases/asthma/pdf/2009_asthma_guidelines.pdf.
- The case-based presentation developed by Dr. Mamta Reddy was produced as a CME DVD as a companion to the NYS Consensus Clinical Asthma Guideline and distributed statewide as recommended by the NYS Consensus Asthma Guideline Expert Panel. The DVD is currently posted online at http://jeny.ipro.org/files/Asthma/ and will be accessible through June 30, 2011 so that health care providers may use it for distance learning opportunities. A total of 226 clinicians have completed the CME evaluation for the course. A total of 1,175 DVD presentations have been distributed by request from the New York State Department of Health distribution center.
- New York State Asthma Outcomes Learning Network is a quality improvement initiative led by the New York State Asthma Program with assistance from NICHQ. This initiative aims to strengthen the capacity of the asthma coalitions and their partners to improve asthma care processes and outcomes for children in a variety of settings. 44 community health centers, primary care providers, SBHCs, day care centers and school health services have participated in this ongoing Quality Improvement Project based on the principles of the Chronic Care Model.
- A survey of influenza rates among children who receive care in NY's SBHCs was completed. An Asthma and Influenza campaign was conducted during the 2008-2009 influenza season.
- Emergency Department data is now available in New York State, and was assessed for its utility in asthma surveillance. 2,334 ED records analyzed for this study. Findings indicated that the data quality for asthma and respiratory diagnoses, patient's age, gender, and zip code information are sufficient for utilization in surveillance and for targeting interventions.
- Asthma hospital discharge data from SPARCS were used to create zip code level data for all 62 NYS counties. During 2008, the NYS Asthma Control Program produced over 700 asthma zip code level maps and tables for the 2004-2006 time period for different age groups and are available on the Department's public website for use by regional asthma coalitions, local health departments, health plans, etc. Feedback from users indicates that this data was particularly useful in assessing, planning, targeting, monitoring and evaluating asthma interventions. (For more information: http://www.nyhealth.gov/statistics/ny_asthma/index.htm) .
- Worked with 10 schools in the Capital District region to explore barriers to implementation of indoor air quality (IAQ) programs and identify strategies to overcoming those barriers. Analysis of the quantitative data from the project surveys and walkthroughs is completed.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control efforts across the agency.				X
2. DOH continues to make asthma information available on the Department's intranet, the public website, and also by hardcopy. The public website includes information on asthma interventions, asthma care and asthma-related patient materials.			X	X
3. The Occupational Lung Disease Registry collects information about work-related asthma.			X	X
4. Medicaid fee-for-service and managed care data have been used to generate age- and county-specific rates. These data were also used to generate asthma-related costs.			X	X
5. User-friendly asthma treatment guidelines are available through the Asthma Program. The finalized Clinical Guidelines build on the NAEPP/NIH guidelines.			X	X
6. The NYSDOH Asthma Control Program is developing processes to increase access to asthma self-management support services individuals with asthma.			X	X
7. The NYSDOH continued to award funds to 11 regional asthma coalitions across the State in an effort to reduce asthma-related morbidity and mortality.		X	X	X
8. School-based health centers develop Asthma Action Plans for students diagnosed with asthma and when indicated, work with other community providers to coordinate care.	X		X	X
9.				
10.				

b. Current Activities

- An Asthma Learning Collaborative focused on improving the system of care for children with asthma and improving outcomes among children with poorly controlled asthma in the areas with the highest asthma hospitalization rates among children 0-19 years in NY. 25 SBHCs in elementary, middle and high schools across the state are participating.
- A medical home initiative is underway in partnership with managed care plans in New York City to reduce asthma health care disparities. The project aims to develop, implement and evaluate healthcare system change interventions that aim to improve asthma control and reduce disparities among blacks and Hispanics enrolled in managed care plans that serve Medicaid and SCHIP recipients in New York City.
- Partnering with managed care plans to improve targeting of in-home services to people with poorly controlled asthma and to integrate environmental management into routine asthma care; targeted at families who live below the federal poverty level.
- Preliminary and formative work for key asthma self management interventions has begun through the efforts of the AE-C and NYS asthma self-management toolkit advisory workgroups.
- 11 new teams, representing schools, daycare facilities, community-based organizations and pediatric settings, will participate in the NYS Asthma Outcomes Learning Network quality improvement initiative.

c. Plan for the Coming Year

- The NYSDOH will issue new funding awards to regional asthma coalitions across the State in an effort to continue to reduce asthma-related morbidity and mortality.

- An evaluation of the in-home services initiative will be completed to make the business case for expansion of the program.
- A collaborative provider education program will be conducted in partnership with the NYSDOH Immunization Program to increase the rates of influenza immunization among asthma patients in the areas with the highest asthma hospitalization rates among children 0-19 years in New York State.
- A finalized plan to expand quality and access to asthma self management services for New Yorkers with asthma and their families will be implemented.
- Asthma surveillance staff will develop and circulate a 2006-2008 NYS BRFSS Asthma Call-Back Survey Summary Report.
- A 5-year Asthma Program evaluation plan will be completed.

State Performance Measure 4: *Teenage Pregnancy Rate for Girls Ages 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		35	34	34	33
Annual Indicator	36.5	36.3	35.1	33.3	33.3
Numerator	14256	14444	14011	13087	13087
Denominator	390618	398091	398693	392716	392716
Data Source				Vital Records	Vital Records
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	33	32	32	31	

Notes - 2009
2008 data are being used as a proxy for 2009.

Notes - 2008
2008 data are being used as a proxy for 2009.

Notes - 2007
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a. Last Year's Accomplishments
- See SPM#1 for additional detail on initiatives and services described.
- Free/low-cost contraceptive serves provided to 343,000 women and 100,000 teens through Family Planning Programs (FPP) statewide. Clinics provide evening/ weekend hrs convenient for adolescents. FPPs conduct education and outreach activities targeting adolescents and families, including collaboration with community and faith-based organizations to provide education about contraception, abstinence, HIV/AIDS, and STDs. Health educators presented programs in over 1100 elementary, middle and high schools in NYS reaching over 131,000.
- The State budget included specific funding for Emergency Contraception (EC). Funds were provided to FPP to purchase and distribute EC and for local outreach and education. The Department also worked with ACOG-NY to develop informational materials for OB/GYNs to encourage their distribution of EC to their patients or reproductive health age.
- Assets Coming Together (ACT) for Youth Center of Excellence (COE) delivered statewide/regional training to adolescent pregnancy prevention providers to incorporate evidence-based youth development programming and principles into programs.
- Intradepartmental Adolescent Sexual Health Work Group (ASHWG) worked to promote a statewide environment conducive to every adolescent (ages 10 -24) achieving optimal sexual

health.
- New York State held an Adolescent Sexual Health symposium in February 2009 through the ACT COE. The symposium included experts on adolescent sexual health, teen pregnancy prevention and key stakeholders.
- The Community-Based Adolescent Pregnancy Prevention (CBAPP) Program employed numerous strategies including school-based comprehensive reproductive health education, peer counseling, parental education, and facilitating access to reproductive health services in 194 high risk zip codes to educate youth, encourage discussions about abstinence and responsible sexual behavior, and provide accurate information about how and where to obtain primary and preventive health services. CBAPP worked with schools and parents to increase communication skills and sexual literacy. Programs provided 4,702 educational sessions to 28,073 participants. Referrals were made for 28,628 adolescents for family planning services.
- The Adolescent Pregnancy Prevention and Services (APPS) program including 26 current contracts was transferred to DOH from the Office of Children and Family Services to allow greater coordination with the DOH's pregnancy prevention programming. APPS provides services to at risk adolescents up to 21, including services to pregnant and parenting teens and their children.
- Comprehensive Prenatal-Perinatal Services Networks implemented activities related to decreasing adolescent pregnancies through provision of family planning information and education on the importance of preconceptional and interconceptional care.
- School-based health centers (SBHCs) provided clinical services to youth in high-need schools including risk assessment and annual comprehensive physical examinations, health education, anticipatory guidance, family planning services pregnancy testing, prenatal care, and follow-up consultation and patient education. Beginning in 2008/09, additional funding was made available to SBHC grantees in high schools to support purchase and distribution of Emergency Contraception.
- The Community Health Worker Program educates women of childbearing age regarding family planning, refers teens to family planning services and follows up to determine whether appointments were kept and services received. See HSCI #04 and 05, NPM #18, SPM #12.
- All NYS hospitals are required to offer emergency contraception to reproductive age women who have experienced a rape. The 76 rape crisis programs in NYS work to ensure that this standard is met, along with DOH standards for care of individuals experiencing rape or sexual assault.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Free/low-cost contraceptive services are provided to teens through Family Planning Programs statewide. Programs conduct education and outreach targeting adolescents to provide education about contraception, abstinence, HIV/AIDS, and STDs.	X		X	
2. Health educators presented programs in over 1100 elementary, middle and high schools in NYS reaching over 131,000 youth.	X		X	
3. Assets Coming Together (ACT) for Youth Center of Excellence (COE) delivered statewide/regional training to adolescent pregnancy prevention providers to incorporate evidence-based youth development programming and principles into programs.			X	X
4. Intradepartmental Adolescent Sexual Health Work Group (ASHWG) worked to promote a statewide environment conducive to every adolescent (ages 10 -24) achieving optimal sexual health.				X
5. CBAPP provides school-based reproductive health education,			X	

peer counseling, parental education, and access to reproductive care in 194 high risk zip codes to educate and encourage discussions about sexual behavior and where to obtain health services.				
6. Comprehensive Prenatal-Perinatal Services Networks implemented activities related to decreasing adolescent pregnancies through provision of family planning information and education on the importance of preconceptional and interconceptional care.			X	
7. School-based health centers provided clinical services, risk assessment, annual physical examinations, health education, family planning services, pregnancy testing, prenatal care, and follow-up consultation and patient education.	X		X	
8. The ACT for Youth Center of Excellence is conducting focus groups with adolescents ages 15 to 19 and young women 20 to 24 to develop preconception health messages and social marketing strategies.				X
9.				
10.				

b. Current Activities

- Continue activities above. See also SPM #1.
- Continued emphasis on cross-program integration of pregnancy STD and HIV work. DOH Adolescent HIV Prevention programs were transferred to the Bureau of MCH. FPP, SBHC, CBAPP and APPS staff meet regularly to coordinate DOH adolescent pregnancy prevention activities, discuss jointly funded contracts, and assist with review of proposals. DOH continues to work with other agencies, including the Office of Children and Family Services and the State Education Department.
- Continued support for rape crisis victim services, with increasing focus on comprehensive primary prevention education and community collaborations to prevent sexual violence before it begins. Statewide training was provided on the national programs, so local providers could have an overview of the program to determine the fit in their community. An additional training was conducted on evidence-based curricula.
- Continue to fund New York City Alliance against Sexual Assault for Project ENVISION, which has a goal of changing, through community mobilization, the social norms that promote and permit sexual violence in NYC to ultimately reduce the perpetration of sexual violence.
- Launched adolescent sexual health media campaign and youth Web site.
- The ACT for Youth Center of Excellence is conducting focus groups with adolescents ages 15 to 19 and young women 20 to 24 to develop preconception health messages and social marketing strategies.

c. Plan for the Coming Year

- Previous activities described above will continue. See also SPM #1.
- With the recent reorganization of the Bureau of Women's Health and the Bureau of Child and Adolescent Health into the Bureau of Maternal and Child Health, it is anticipated that coordination and integration of services will become more seamless and efficient.
- The Family Planning Program is issuing an RFA for the next 5-year funding cycle to begin January 2011.
- The SBHC program will continue to work with providers to enhance the provision of age-appropriate reproductive health services on-site or by referral. The SBHC program plans to incorporate reporting on provision of age-appropriate Reproductive Health screening as a required indicator on the program's reporting tool, and expand the measures associated with it.
- New York will continue to utilize the website developed for the Adolescent Sexual Health Media Campaign (www.nysyouth.net) to provide continually updated health information for youth.

- A new five year procurement that starts on July 1, 2010 will focus on Sexual Violence Prevention. Providers will implement primary prevention programs designed to prevent sexual violence before it occurs by developing strategies to plan, implement and evaluate primary prevention interventions to best meet the needs of their community. As part of the primary prevention education, agencies are expected to implement evidence-based curricula such as Safe Dates, Girls Circle, The Council for Boys and Young Men (previously known as Boys Council), Men of Strength Clubs (A component of Men Can Stop Rape), Expect Respect, or Mentors in Violence Prevention (MVP).
- The Adolescent Health Unit will release a competitive solicitation in the summer of 2010 for contracts beginning 1/1/11. This new initiative, Comprehensive Adolescent Pregnancy Prevention, will combine the current CBAPP and APPS programs.
- Results from preconception health focus groups of adolescents will be used to develop a social marketing plan, and will be shared with internal and external partners to inform current public health programs and social marketing strategies.

State Performance Measure 6: *Percent of infants who are put down on their backs to sleep.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		82	84	84	85
Annual Indicator	67.2	71.9	70.5	75.1	75.1
Numerator					
Denominator					
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	85	86	86	

Notes - 2009
2008 data are being used as a proxy for 2009. Data are from the NYS PRAMS Survey which includes women residing in NYS outside of NYC

Notes - 2008
Data are from the NYS PRAMS Survey which includes women residing in NYS outside of NYC

Notes - 2007
Data are from the NYS PRAMS Survey which includes women residing in NYS outside of NYC.

a. Last Year's Accomplishments
- According to the 2008 PRAMS Survey, 75.1% of mothers reported putting their babies on their back to sleep. This represents a 4.6% increase over 2007 and the highest level in recent history. Some of the progress can be attributed to the work of the New York State Center for Sudden Infant Death.
- During the early part of 2008 the department worked closely with the Center on replacing the department's SIDS risk reduction information cards with a new, more attractive product that also incorporated other safe sleep recommendations. Simultaneous, the center was modernizing its materials and approach for risk reduction. The Department also worked with the State Office of Children and Family Services (OCFS) on safe sleep messages and materials. They released several safe sleep initiatives targeted toward lower socio-economic clientele.
- Statewide training efforts continued. Police, firefighters, emergency medical personnel and public health nurses were educated on appropriate responses to SIDS. The Department oversees notification of infant deaths by funeral directors, coroners and medical examiners. The Center for Sudden Infant Death at SUNY Stony Brook and its satellite offices provide training and

family support services. For families that have experienced any infant death in the last year, they provide a 1-800 "warm line" for support, information and referral to self-help groups and other mental health services. The Center also arranges a home visit by a public health nurse. Newsletters are sent on a regular basis, and are a very popular item. The Center also released health education materials about the dangers of placing infants to sleep in adult beds.
- The department completed an 11 year (1993-2003) assessment of child deaths age 28 days to 18 years old utilizing data from over 20,000 death certificates. The assessment revealed that over 40% of child deaths in NYS may be preventable. More specifically, about 1,500 children of age 28 days through 18 years died annually during the years examined and approximately 40% of these deaths are categorized as accidents, homicides and suicides. An additional 12% of deaths are categorized as sudden and unexpected infant deaths, "ill defined" or "unknown and unspecified". It was determined that death certificates data did not provide sufficient information as the basis for new or improvement of existing prevention or risk reduction initiatives.
- Infant and child deaths are frequently a sentinel event that alerts a community to health and safety issues for infants and children. Efforts to understand the entire spectrum of factors that lead to a death can help prevent others deaths, poor health outcomes, injury or disability in other children. Of the 1,500 annual child deaths very little is known collectively at the local or state level about the factors contributing to these deaths. Death certificates are the only source of information on all child deaths in NYS and they do not provide the information necessary to prevent future deaths.
- Sudden Infant Death Syndrome (SIDS) is a leading cause of death among New York infants one month to one year of age. During 2008, 74 deaths were classified as SIDS, a slight increase over the 71 that occurred in 2007. The department contracts with State University of NY Research Foundation to operate its SIDS program. The program functions as the New York State Center for Sudden Infant Death located at SUNY Stony Brook with 4 subcontracted regional offices. The programs conducted 125 educational programs and 50 public awareness programs. They also distributed 10,000 pieces of literature and maintain membership in 25 coalitions addressing infant mortality risk reduction. The contractor performs a brief telephone assessment of families experiencing an infant death, offers information and referrals to appropriate services.
- Shared SIDS risk reduction materials with the Comprehensive Prenatal-Perinatal Services Networks, which used the materials to implement strategies to promote safe sleep, including media campaigns to raise community awareness.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. New SIDS risk reduction materials were developed to increase the awareness of the “Back to Sleep” message.			X	X
2. Statewide training for police, fire fighters, emergency medical personnel and public health nurses is provided on appropriate responses to SIDS.			X	X
3. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provide training and family support services. The Center also arranges a home visit by a public health nurse.		X	X	X
4. For families that have experienced any infant death in the last year, the 1-800 “warm line” for support, information and referral to self-help groups mental health services is available.		X	X	X
5. The Department’s “Welcome to Parenthood” informational package has been revised to contain more information on safe infant sleep.			X	X
6.				
7.				
8.				

9.				
10.				

b. Current Activities

- While the existing program is effective in addressing SIDS, it is not structured to address the much larger public health issue of other preventable causes of infant and child deaths. Therefore, the department entered into a partnership with the OCFS to expand and improve its 14 county child fatality review system that focuses of child abuse deaths. The partnership has yielded results with OCFS adopting the National Center for Child Death Review data collection system. The plan is to use the system to collect individual data on all deaths reviewed by local child fatality review teams. The data collection system will generate information for local and state officials that will be used to help design prevention measures.
- A procurement document was developed to solicit applications to fund an organization that will significantly improve the Department's child fatality review and prevention program in NYS in partnership with the OCFS. The procurement will fund a not-for-profit organization to help create new local child fatality review teams, expand the number of deaths reviewed by existing teams, assure that cases are entered in the data system and provide financial and technical support to initiate local prevention efforts. It is expected that these local teams will enhance interagency cooperation and expand the number of local agencies participating in prevention efforts.

c. Plan for the Coming Year

- The expanded and improved child fatality review and prevention system will be a component of the department's new prevention agenda. It will enable a state level epidemiological analysis of why children die and inform data driven prevention efforts in priority areas such as infant mortality, unintentional injuries and teen suicide. The department will build on the existing partnership with OCFS to establish a multi-agency, state level workgroup. State workgroup membership will be modeled after required members of local teams. This will facilitate state workgroup members encouraging their local counterparts to fully participate on local teams. It will also provide the state workgroup the technical expertise they will require to recommend state program or policy changes to protect children.
- The Department will assure that SIDS risk reduction activities including placing infants on their back to sleep will remain a priority as well. The improved programs, as discussed previously, will provide an opportunity to reach even more parents with the information they need about SIDS and safe sleep practices for infants. In addition to large group presentations, the new contractor will use electronic methods to disseminate information including a public website, web casts, video and increased use of text and social marketing tools to provide more information directly to pregnant women, parents with infants and professionals. The efficiencies created by the new approach will enable the contractor to work on expanding and improving local child death review and prevention while maintaining a high performance SIDS program. The department will work with OCFS to assure adequate quantities and quality data are being collected by local teams.
- The Department will also create a state level work group that will be charged with reviewing data collected by local child death review teams and advising the Department regarding changes in state programs, policy or law that may reduce the number of child deaths.

State Performance Measure 7: *Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0.1	0.1	0.1	0.1
Annual Indicator	0.1	0.1	0.1	0.1	0.1

Numerator	1291	1324	1280	1368	1368
Denominator	1318372	1385081	1396874	1403050	1403050
Data Source				SPARCS	SPARCS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0.1	0.1	0.1	0.1	

Notes - 2009
2008 data are being used as a proxy for 2009

Notes - 2008
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Notes - 2007
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a. Last Year's Accomplishments
- All school-based health centers (SBHCs) provide psychosocial assessment as part of the initial assessment and visit, the annual comprehensive physical examination and at follow up visits, when indicated. Students and families are offered individualized education regarding safety issues and abuse, and when indicated, mental health services are made available on site or by referral. Potential abuse and neglect cases are reported. SBHC staff follow up on all referrals for mental health services and behavioral issues. Over 171,000 students have access to mental health services through school-based health centers. 63% of school-based health center sites in New York State provided onsite mental health services, and 37% provided mental health services through referral.
- The ACT for Youth Center of Excellence (COE) sponsored a training series for DOH-funded youth-serving providers that highlighted curricula focused on building skills and knowledge necessary for healthy relationships among adolescents designed especially for work with young people who are at risk for early and unplanned pregnancy, who are pregnant, or who are already parenting. The COE has also developed youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators; and mentoring programs. The COE also provided information to youth serving providers on self-injurious behavior through their website and list serve.
- All DOH-funded adolescent sexual health programs employ a youth development/youth empowerment approach to build resiliency and developmental assets.
- The Emergency Medical Services for Children Advisory Committee developed a White Paper with recommendations for NYSDOH Commissioner for the standardization and regionalization of pediatric hospital care. This White Paper provided evidence that the standardization and regionalization of pediatric care in NYS will improve health outcomes for children. EMSC continues moving forward garnering support and stakeholder input to the regionalized system to be developed.
- NYSDOH continues to collaborate with the Office of Mental Health and the Office of Alcohol and Substance Abuse Services through cross system work groups, such as the NYS Youth Development Team.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBHCs provide psychosocial assessment as part of visits, when indicated. Students and families are offered individualized education on safety issues and abuse, and when indicated, mental health services are made available on site or by referral.	X			

2. The ACT for Youth Center of Excellence developed youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators; and mentoring programs			X	X
3. OMH is working with the DOH to ensure child mortality reviews are conducted in every county and gaps in service identified help shape youth violence prevention programs (including suicide prevention and anti-bullying and the impact) in communities.				X
4. OMH trained some counties on youth violence prevention programs so they can train school districts in SAFETALK (suicide awareness for everyone), TELL, ASK, LISTEN, and Keep Safe, and Applied Suicide Intervention Skills training (ASIST).				X
5. School-Based Health Centers assess students for suicide risk, and provide enhanced mental health services, directly or by referral.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- COE updated an article on the ACT for Youth website on non-suicidal self-injury in adolescence and how to proactively address this issue.
- Office of Mental Health (OMH) is working with NYSDOH to ensure child mortality reviews are conducted in every county and gaps in service identified help shape youth violence prevention programs (including suicide prevention and anti-bullying and the impact on suicide prevention) in communities.
- Office of Mental Health trained some counties on youth violence prevention programs so they can train school districts in SAFETALK (suicide awareness for everyone), TELL, ASK, LISTEN, and Keep Safe, and Applied Suicide Intervention Skills training (ASIST).
- OMH provides Post-intervention services and policy direction for schools on suicide prevention. These trainings are also offered to county offices including the county health departments, probation, DSS and youth bureaus routinely, and as part of the state plan for suicide prevention. Emergency Medical Services for Children Advisory Committee is presenting a White Paper on the standardization and regionalization of pediatric hospital care to the NYSDOH Commissioner of Health.
- School-Based Health Centers assess students for suicide risk, and provide enhanced mental health services, directly or by referral.
- Youth development is a focus of all youth-related activities.
- The COE is providing information on gang-related violence among youth to all adolescent sexual health providers.

c. Plan for the Coming Year

- Identification and treatment of mental and behavioral health concerns will continue to be a core element of services provided through SBHCs. With the pending federal CMS approval of Medicaid coverage for psychotherapy provided by social workers in SBHCs, it is anticipated that more mental health services will be provided on-site and thereby strengthen the SBHCs' ability to address this growing health concern.
- The ACT for Youth Center of Excellence will continue to incorporate relevant current and emerging topics related to adolescent mental health and wellbeing into its ongoing training and

technical assistance activities for DOH-funded adolescent health programs.
- Address domestic violence as a risk factor for further youth violent behaviors through a Memorandum of Understanding with the Office for the Prevention of Domestic Violence to provide outreach to programs serving women and children, including hospitals, prenatal care providers, family planning providers, Community Health Worker Programs, Comprehensive Prenatal-Perinatal Services Networks and others in New York State. OPDV will provide trainings, presentations, referrals and technical assistance to staff working in these programs on the identification and screening for domestic violence.

State Performance Measure 8: *Percent of High School Students who had five or more drinks of alcohol in a row at least once in the Last Month*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		19	18	18	18
Annual Indicator	23.9	23.9	24.9	24.9	23.8
Numerator					
Denominator					
Data Source				YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	18	18	18	18	

Notes - 2009
2009 data are from the 2009 YRBS (biannual) survey. There are no numerator or denominator data available from this survey

Notes - 2008
2008 data are from the 2007 YRBS (biannual) survey. There are no numerator or denominator data available from this survey

Notes - 2007
Numerator and Denominator data are not available (2007 YRBS survey data)

a. Last Year's Accomplishments
- DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy. Beginning in 1999, OASAS involved multiple human service agencies at the county level in identifying alcohol and substance abuse risk and protective factors, and in strengthening and expanding local partnerships for alcohol and substance abuse prevention. Fifteen counties were funded for three years to develop and implement countywide, prevention- and results-focused work plans. These work plans identified, re-directed, and leveraged state and local resources for a comprehensive, multi-system approach to alcohol and substance abuse prevention at the local level.
- OASAS continued to promote its nationally recognized Underage Drinking: Not a Minor Problem Media Campaign, which includes helpful information for youth, parents, colleges and communities. Title V programs promoted the campaign to health care providers.
- The focus of ACT for Youth, (Assets Coming Together for Youth) is to empower youth and to prevent abuse, violence and risky sexual activities, all of which are associated with low self-esteem; poor decisions; alcohol and substance use. Specific on-line training and publications were provided on adolescent risk taking behaviors presented by Dr. Valerie Reyna, from Cornell University.
- OASAS continued to highlight Alcohol Awareness Month in April. April 8 marks National Alcohol

Screening Day (NASD), calling attention to the impact that alcohol has on overall health. The program aims to encourage people of all ages to take a look at the way they use alcohol, so that they may take steps to reduce their alcohol intake, if necessary. In addition, Alcohol-Free Weekend takes place each year on the first weekend of April and is designed to raise public awareness about the use of alcohol and how it may be affecting individuals, families and businesses.

- OASAS is conducting the first ever statewide assessment of youth (7th -12th grade) risk and protective factors for problem behavior. These factors predict levels of substance use, school drop-out, violence, delinquency and gambling, behaviors that are also measured by the survey. Surveys were administered in sampled schools every two years starting in the Fall of 2008. Participating NYS counties, schools, service providers and prevention coalitions will be able to compare their risk and protection factor levels to county and state norms, then tailor their prevention service plans to better support healthy youth development.
- The DOH AIDS Institute administers grant funding to a range of community-based organizations to address non-HIV related health and human service needs of Lesbian, Gay, Bi-Sexual, Transgendered communities. Over half of these contractors targeted issues related to alcohol, substance abuse and self-inflicted injury.
- School-based health centers conduct routine risk assessments that include questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available for consultation/intervention where onsite services are not provided. Reporting of the delivery and documentation of age-appropriate anticipatory guidance on an annual basis was added to the SBHC quarterly reporting tool as a required quality indicator.
- As part of its Quality Assurance Reporting Requirements (QARR) for managed care plans, the Department's Office of Health Insurance Programs collects data from managed care plans, including Medicaid Managed Care (MMC) and Child Health Plus plans, on preventive services for adolescents. This composite measure assesses the percentage of adolescents ages 12 to 17 enrolled in the plan who had at least one outpatient visit that included four separate indicators of preventive health care, including assessment and counseling for education about the risk of substance use including alcohol. Plans conduct a variety of quality assurance and improvement activities to maintain and improve performance in this and other areas monitored.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy.				X
2. OASAS is conducting an assessment of youth risk and protective factors for problem behavior. Communities and providers will be able to compare their risk levels to county and state norms and tailor efforts to support healthy youth development.				X
3. The DOH AIDS Institute administers grant funding to organizations to address service needs of Lesbian, Gay, Bi-Sexual, Transgendered communities. Providers targeted issues related to alcohol, substance abuse and self-inflicted injury.			X	
4. SBHC's conduct routine risk assessments that include questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available for consultation/intervention where onsite services are not provided.	X			
5. DOH participates on the ACTION Council (Addictions Collaborative To Improve Outcomes for New York), providing an integrated response to the negative consequences of addiction of New Yorkers by coordinating resources and interventions.				X

6. Title V programs will emphasize the role of alcohol and substance use on risky behavior and decision making. The Center of Excellence will incorporate training on alcohol and substance use in the context of other public health program work.				X
7.				
8.				
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10.				

b. Current Activities

- No major changes as previous activities have continued.
- DOH participates on the ACTION Council (Addictions Collaborative To Improve Outcomes for New York), which was created to address the negative consequences of addiction as they impact health, safety, welfare and education of New Yorkers through an integrated response to coordinate resources and interventions. One issue being looked is to foster interagency coordination regarding Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders.

c. Plan for the Coming Year

- Continue current activities.
- All Title V related programs will continue to employ a youth empowerment/youth development focus, with continued emphasis on the role of alcohol and substance use on risky behavior and decision-making. The Center of Excellence will incorporate training on alcohol and substance use in the context of other community-based public health program work.
- The SBHC program will continue work to improve the documentation of age appropriate anticipatory guidance provided by SBHCs in the medical record to prompt follow-up guidance at future visits so as to reinforce the safety and injury prevention education.
- Since dating abuse is frequently related to alcohol abuse, the Department will continue to support Rape Crisis and Sexual Violence Prevention Programs throughout the state. These providers focus on the provision of victims' services as well as educational programs in school or other venues where youth gather. These programs employ methods for the primary prevention of sexual violence and use evidence-based programs that employ role-playing and other methods to help youth make positive decisions.

State Performance Measure 9: *Percent of High School Students Who Smoked Cigarettes in the Last Month*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		5	5	5	5
Annual Indicator	16.2	16.2	13.8	13.8	14.9
Numerator					
Denominator					
Data Source				YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	4	4	

Notes - 2009

2009 data are from the 2009 (biannual)Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

Notes - 2008
2008 data are from the 2007 (biannual)Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

Notes - 2007
Numerator and Denominator data not available (2007 YRBS survey data).

a. Last Year's Accomplishments
- New York State cigarette excise tax is $2.75 per pack, which is the fourth highest in the nation. Raising the price of cigarettes discourages youth smoking.
- Enforcement of a tough indoor air law continued, banning smoking in public places, including restaurants and bars.
- The Tobacco Control Program continues to fund Youth Action Partners to work with youth to become activists in the movement to change community norms related to tobacco use. These 16 programs engage middle and high school youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities.
- New York state law requires that all tobacco products be kept behind the counter.
- The State also funds local Tobacco Control Community Partnerships in every county of the state. These partnerships work to change the community environment to support the tobacco-free norm. Partnerships engage local stakeholders, educate community leaders and the public, and mobilize the community to strengthen tobacco-related policies to restrict the use and availability of tobacco products and tobacco product promotion and limit opportunities for exposure to second hand smoke.
- The Tobacco Control Program funded contractors' work with local leaders to educate them on the public health benefits of passing local ordinances on smoking in public places, removing tobacco products from the reach of youth, and reducing tobacco advertising in areas frequented by youth.
- Medicaid Prenatal Care, WIC and the Community Health Worker Programs assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.
- Comprehensive Prenatal Perinatal Services Networks create awareness of the dangers of smoking, particulary in pregnancy.
- New York makes smoking cessation assistance available through a toll-free hotline, which provides free coaching, and nicotine replacement therapy to eligible callers and purchase of smoking cessation products is available through Medicaid.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Tobacco Control Program continues to fund Youth Action Partners to change community norms related to tobacco use. Programs engage youth in activities aimed at de-glamorizing and de-normalizing tobacco use in their communities.		X		
2. Tobacco Community Partnerships engage, educate and mobilize the community to strengthen policies to restrict the use and availability of tobacco products and promotions and limit opportunities for exposure to second hand smoke.			X	
3. The Tobacco Control Program supported educational efforts to pass local ordinances banning smoking in public places, removing tobacco products from the reach of youth, and reducing tobacco advertising in areas frequented by youth.			X	

4. Medicaid Prenatal Care, WIC and the Community Health Worker Programs assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- NYSDOH continued to implement successful programs as outlined above.
- In February 2010, the tobacco control program received federal stimulus funding to reduce youth smoking prevalence and tobacco product sales to minors by reducing the impact of retail tobacco product marketing on youth. This is accomplished by Community Partnership and Youth Action contractors implementing a set of educational activities to increase awareness of the impact that tobacco product marketing and tobacco retailer density have on youth smoking.

c. Plan for the Coming Year

- Title V will continue to collaborate with Division of Chronic Disease Prevention and Adult Health, which is the DOH lead for smoking related public health programming.

State Performance Measure 10: *Percent of children in the birth year cohort who were screened for high blood lead before the age of two.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		87	87	80	81
Annual Indicator	63	69.5	72.5	74	74
Numerator					
Denominator					
Data Source				NYS Lead Tracking System	NYS Lead Tracking System
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82	83	83	83	

Notes - 2009

Data are reported for the birth cohort two years prior to reflect children turning two years old in that year – i.e., data reported for 2008 are for the 2006 birth cohort. Indicators for years prior to 2008 have been updated with more complete data. 2008 data are preliminary pending publication of surveillance report.2008 data are used as a proxy for 2009. Data are for New York State excluding New York City.

Notes - 2008

Data are reported for the birth cohort two years prior to reflect children turning two years old in that year – i.e., data reported for 2008 are for the 2006 birth cohort. Indicators for years prior to 2008 have been updated with more complete data. 2008 data are preliminary pending publication of surveillance report. Data are for New York State excluding New York City

Notes - 2007
Data are from the NYS Lead Tracking System, based on the 2004 birth cohort ,with testing through 2007.

a. Last Year's Accomplishments
- New York State Public Health Law and implementing regulations require universal blood lead testing of all children at ages one and two years, and a risk assessment at least annually, with blood lead testing as indicated, for children up to age six years.
- Preliminary statewide surveillance data for 2009 demonstrate continued improvements in the proportion of children receiving blood lead screening tests at or around age one year (69.5 %) and age two years (65.4%).
- Although it is no longer tracked by the state because it has been replaced by other more relevant metrics, the percent of children tested at least once by age 24 months has also continued to increase, as noted in the data table above (old measure).
- In June 2009, the Department's Lead Poisoning Prevention Program (LPPP) distributed a statewide mailing of a Commissioner's letter to over 22,000 health care providers to promote routine lead testing and use of new educational materials related to the importance of blood lead test results below 10 mcg/dL. The materials reinforced routine blood lead testing and primary prevention messages.
- Following the release of updated federal recommendations for lead testing of Medicaid children from CDC, LPPP staff initiated a project to match the lead registry (LeadWeb) with the Medicaid database for the 2004 upstate New York birth cohort to better assess lead testing and incidence rates among the Medicaid eligible population. Preliminary data analysis suggests that while Medicaid children represent 39% of the children tested, they represent 77% of children with lead poisoning, reinforcing the need for routine lead testing of Medicaid eligible children in New York State. Additional analysis is planned.
- Revisions to state regulations, effective June 2009, authorized physician office laboratories and limited service registrant laboratories to conduct blood lead testing using point of care testing devices. These regulations support in office testing to help improve access to blood lead tests for children and also require reporting of these results to the Department.
- In 2009, Public Health Law was amended to authorize the linkage of the NYS Immunization Information System (NYSIIS) with the statewide childhood blood lead registry (LeadWeb). LPPP began work with the NYSIIS vendor to initiate the development of the linkage between LeadWeb and NYSIIS. It is anticipated this system will prompt and reinforce lead testing of patients, and provide a tool for NYSDOH and LHDs to systematically identify children who have not been tested for lead to target quality improvement and compliance activities.
- The LPPP worked with DOH's Wadsworth Laboratory and Office of Health Insurance Programs to develop and implement new Medicaid reimbursement for office-based lead testing. This reimbursement became effective September 1, 2009.
- The LPPP contracted with three Regional Lead Resource Centers (RLRCs) in five teaching hospitals throughout the state to provide expert clinical support, education and outreach for LHDs and health care providers to improve lead testing and other preventive practices.
- LPPP provided grant funding and technical support to Local Health Department (LHD) lead poisoning prevention programs, including a strong emphasis on improving local lead screening rates. LPPP staff reviewed and provided technical assistance to counties on annual work plans and quarterly reports to assure effective strategies to increase lead testing rates were implemented.
- Enhanced reporting functions were implemented in the Department's lead registry, LeadWeb, to aid LHDs in tracking and contacting children due for two-year old screening tests.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NYS Public Health Law and implementing regulations require universal blood lead testing of all children at ages one and two years, and a risk assessment at least annually, with blood lead testing as indicated, for children up to age six years.				X
2. The LPPP distributed a statewide mailing of a Commissioner's letter to over 22,000 health care providers to promote routine lead testing and use of new educational materials related to the importance of blood lead test results below 10 mcg/dL.			X	
3. The LPPP began work with the NYS Immunization Information System (NYSIIS) vendor to start development linking LeadWeb and NYSIIS. The link will help identify children needing lead testing and target quality improvement and compliance activities.			X	X
4. LPPP contracted with 3 Regional Lead Resource Centers in 5 teaching hospitals in the state to provide expert clinical support, education and outreach for LHDs and health care providers to improve lead testing and other preventive practices.			X	
5. LPPP is working with OHIP to update the analysis of matched LeadWeb/Medicaid dataset to assess lead testing rates among children enrolled in Medicaid, and to apply findings to policy and program strategies to improve testing of at-risk children.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Continuation of all activities above.
- Following identification of adopted Chinese children with elevated blood lead levels, DOH sent an alert to pediatricians on testing foreign born adopted children. Collaborated with the NYS Adoption Service to alert adoption agencies to encourage testing of foreign-born children.
- Added provider education link to DOH Health Commerce System. Developed and posted case study to reinforce state lead testing and follow-up requirements.
- Hosted a webinar for LHD staff on practices to improve local testing rates.
- With feedback from the RLRCs, drafted updated guidelines for prevention/ management of lead poisoning in pregnant women.
- Continue to develop link between LeadWeb and NYSIIS. Business rules developed for data viewing, entry and exchange. User acceptance testing in progress for implementation later this year.
- Lead-related Web pages on the Department's public web site updated for ease of use and to post the latest consumer and professional publication materials.
- Collaborated with the NYS Bureau of Refugee and Immigration Assistance to develop a video about lead prevention and testing in refugee and immigrant communities, disseminated to LHDs and refugee and resettlement agencies.

c. Plan for the Coming Year

- Continue to facilitate appropriate use of portable "point of care" lead testing technology to reduce key barriers to lead testing and to assure reporting of lead test results from all laboratories.

- Support the ongoing implementation of the new lead module in NYSIIS to support improvements in lead testing and streamlined electronic reporting of office-based lead testing. Conduct Webinar training sessions for providers and their office staff. Complete and implement requirements for additional prompt and reporting functions to support further improvements in testing rates.
- Continue contracts with a statewide network of RLRCs to provide clinical support, education and outreach for LHDs and pediatric health care providers to improve lead testing and other preventive practices.
- Continue to provide grant and technical support to LHDs statewide to improve lead testing of children as part of comprehensive local lead poisoning prevention programs. Provide LHDs with current local data to support targeting and monitoring of local strategies, including expanded LeadWeb reporting functionality, along with annual work plan guidance, oversight, and technical assistance to assure effective strategies are utilized to improve local testing rates.
- Continue and expand educational messages and materials for the public and parents to increase the demand for lead testing.
- Continue work with a School of Public Health graduate student intern to develop and implement additional materials and mechanisms for providing continuing education to health care providers related to lead testing and other lead prevention activities.
- Work the Department's Office of Health Insurance Programs to enhance and update the analysis of matched LeadWeb/Medicaid dataset, including NYC data, to assess lead testing rates among children enrolled in Medicaid, and to apply findings to policy and program strategies to improve lead testing of at-risk children.

State Performance Measure 11: *Percent of High School Students who watched 3 or more hours of TV on an average school day.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		40	38	34	33
Annual Indicator	41.9	41.9	35.3	35.3	32.7
Numerator					
Denominator					
Data Source				YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	32	31	30	30	

Notes - 2009
2009 data are from the 2009 biannual YRBS survey. Numerator and Denominator data are not available

Notes - 2008
2008 data are from the 2007 biannual YRBS survey. Numerator and Denominator data are not available .

Notes - 2007
Numerator and Denominator data are not available (2007 YRBS survey data)

a. Last Year's Accomplishments
- The goals of the Department's obesity prevention program include increasing fruit and vegetable consumption, increasing physical activity and decreasing television and other screen time viewing. This is done through policy, systems and environmental changes in a variety of settings and programs.
- The School Nutrition and Physical Activity Best Practices Toolkit is available in an electronic

version on the DOH public website.
- The Healthy Kids, Healthy New York After-School Toolkit, with model guidelines for nutrition, physical activity and screen time use, is available in an electronic version on the DOH public website. Guideline implementation regional training was provided to 60 after-school program providers.
- The WIC Program assesses screen time and provides participant-centered nutrition counseling and education on healthy lifestyles. Training on FitWIC, a physical activity initiative, was completed with WIC local agency staff at all 100 agencies from January 2005 to June 2007 on how to interact with WIC families to focus on good health and physical activity rather than weight. FitWIC teaches simple age-appropriate movements, and incorporates cultural games and activities that support a life-long habit of staying active. The WIC Program also has a Special Projects Grant funded by USDA to support evaluation of the FitWIC statewide implementation.
- New York has laws mandating physical education in schools and that all students complete a mandated, semester-long course in health.
- Since 2005, the Healthy Heart Program has funded local organizations that have worked with 1,375 schools (reaching 768,064 students) statewide to improve policy and environmental supports for nutrition and physical activity. Physical activity improvements include increasing active time during physical education, increasing the number of children walking or bicycling to school, increasing opportunities for physical activity (e.g., installing climbing walls, providing snow shoes, etc.), improving or maintaining recess times, and prohibiting the use of physical activity as a punishment. Nutrition policies adopted include: increasing the availability of low-fat milk, increasing the number of healthful options sold in school stores and vending machines, prohibiting the use of food for reward or punishment, and prohibiting the sale of unhealthy foods as fund raising activities. MCH Block Grant funds support approximately 50% of this activity.
- The Bureau of Community Chronic Disease Prevention (formerly the Bureau of Health Risk Reduction) conducted the statewide Turnoff Week in April and September. Toolkits and posters were provided to school and community representatives to help decrease TV viewing and increase physical activity.
- The Bureau also funded contractors to provide the "Do More, Watch Less" TV viewing reduction curriculum in afterschool programs.
- Annual BMI measurement and documentation was added as a required quality measure to the SBHC program's work plan and quarterly reporting tool.
- SBHCs are required to have documented annual BMI for all enrolled students.
- As part of the School-based Health Center Improvement collaborative, obesity was an optional quality measure used for this project. Of the 25 teams that volunteered to participate, 19 chose to work on the obesity measure. Required activities for the obesity quality measure included establishing a mechanism to monitor students with a BMI at or above the 85th percentile and at or above the 95th percentile and development of an obesity action plan which often included TV reduction.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Statewide Turnoff Week was conducted, and the Healthy Kids/ Healthy New York Toolkit was released.			X	X
2. Obesity Prevention Program encourages children to eat 5 (fruits and vegetables)-a-day, get at least one hour of exercise a day and limit their screen time to less than 2 hours/day.			X	X
3. “Steps to a Healthier New York” is in four counties in NYS. This is an approach to working with entire communities. Each site must have a school coordinator to pull the community activities into the school.			X	X
4. The School Nutrition and Physical Activity Toolkit is on the public website.			X	X

5. Twenty-four school districts participated in the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools.			X	X
6. The WIC Program continues to promote FitWIC through 1:1 counseling sessions and facilitated group sessions with exercise/activities.			X	X
7. BMI data collected as part of the Student Weight Status Category Reporting System are being analyzed and disseminated.			X	X
8. New York has laws mandating physical education in schools and that all students complete a mandated, semester-long course in health. The “Do More, Watch Less” curriculum was implemented.			X	X
9. 250 schools made healthy changes affecting over 75,000 students.			X	X
10. Annual BMI measurement and documentation was added as a required quality measure to the SBHC program’s work plan and quarterly reporting tool.	X		X	

b. Current Activities

- This measure will be tracked through the Youth Risk Behavior Survey.
- See National Performance Measure 16.
- Currently, the Department has a number of initiatives that address improving physical activity, including the Coordinated School Health Team; "Strategic Alliance for Health" in four counties; the School Nutrition and Physical Activity Toolkit; and FitWIC, a physical activity initiative in WIC.
- The WIC Program also has a Special Projects Grant funded by USDA to support Fit WIC research and continue activities/exercises at WIC local agencies.
- New York continues to mandate physical education in schools and that all students complete a mandated, semester-long course in health.
- A sample of schools and school districts continue required reporting of Student Weight Status Category data to the DOH.
- Obesity Prevention Program contractors will continue implementation of "Do More, Watch Less" curriculum.
- Healthy Kids, Healthy New York After-School Toolkit statewide dissemination continues.

c. Plan for the Coming Year

- Legislation is pending to improve school nutritional programs. The Diabetes Prevention and Control Program in collaboration with the Obesity Prevention Program will implement a new procurement entitled Creating Healthy Places to Live, Play, Work and Learn. Funded contractors will implement strategies to create policy, systems and environmental changes that will lead to the following outcomes:

o Increased physical activity and reduced sedentary behavior among children.
o Decreased television viewing in child care and after-school settings.
o Increased access to and consumption of healthy foods and reduced access to and consumption of foods with minimal nutritional value among children.

- Obesity Prevention Program contractors will expand implementation of "Do More, Watch Less" curriculum. Contractor work will continue to expand the adoption, implementation and evaluation of the Healthy Kids, Healthy New York After-School Initiative, to include a baseline survey of nutrition, physical activity and screen time practices in after-school care settings by after-school care organizations and networks.
- The SBHC QI collaborative will build upon their BMI/Obesity improvement work through all sponsored SBHCs.

State Performance Measure 12: *Percent of Women that felt down, depressed or hopeless always or often after their baby was born.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		11.5	11.4	8	8
Annual Indicator	9.9	8.3	7	7.5	7.5
Numerator					
Denominator					
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.5	7.5	7	7	

Notes - 2009
2008 data are being used as a proxy for 2009. Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC

Notes - 2008
Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC

Notes - 2007
Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC.

a. Last Year's Accomplishments
- The Department's 23 Community Health Worker Programs have policies and procedures for conducting perinatal depression screening and making referrals for further evaluation if needed. Community Health Workers educate pregnant and postpartum clients about perinatal depression including signs and symptoms and the availability of help and local resources. All pregnant and postpartum clients are screened for depression using a standardized screening tool such as the Edinburgh Postnatal Depression Scale. CHWP coordinators closely supervise all cases where there is a positive screen. In 2009 the CHWP served 3,211 women, of whom 99 pregnant and 74 postpartum women were referred for further evaluation and treatment of depression.
- Comprehensive Prenatal-Perinatal Services Networks implement a variety of strategies designed to improve pregnancy outcomes including improving access to health care services and promoting positive behaviors. CPPSN activities in 2009 around prenatal/postpartum depression included:
o Mothers and Babies of Central New York conducted consumer education on postpartum depression including signs and symptoms and available resources.
o The Perinatal Network of Monroe County includes information, resources and referral sources on perinatal depression on their websites.
o Buffalo Prenatal-Perinatal Network conducted provider training on barriers and gaps in services related to perinatal mood disorders.
o Lower Hudson Valley Perinatal Network conducted a consumer education event on perinatal depression among African-American women. 85 women attended the event. In addition, the Network trained 22 providers on perinatal mood disorders.
o Maternal and Infant Services Network trained facilitated the creation of the Maternal Depression Task Force and has linked with the Mental Health Association of Ulster County to raise awareness of pediatricians and family practice offices.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHW ‘s screen and educate all pregnant and postpartum clients for depression using a standardized screening tool and make referrals for further evaluation if needed.		X	X	
2. Comprehensive Prenatal-Perinatal Services Networks implement a variety of strategies designed to improve pregnancy outcomes including improving access to health care services and promoting positive behaviors.			X	
3. Comprehensive Prenatal/Perinatal Networks continue to promote awareness of and provide information on dealing with perinatal depression.			X	
4. The Growing up Healthy Hotline continues to take calls on perinatal depression and refer callers to appropriate services.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Perinatal depression materials are available on the NYSDOH public website.
- The Growing Up Healthy Hotline continues to take calls on perinatal depression and refer callers to appropriate services.
- Community Health Workers continue to screen clients for signs and symptoms of depression, both prenatally and in the postpartum period. Comprehensive Prenatal/Perinatal Networks continue to promote awareness of and provide information on dealing with perinatal depression.
- NYSDOH staff continue to work with the Office of Mental Health and various stakeholders, including the recently established Governor's Early Childhood Advisory Council, to plan future activities.

c. Plan for the Coming Year

- Continue to implement current activities (population-based services).
- Both the Comprehensive Prenatal/Perinatal Service Networks and the Community Health Worker program are due to be re-solicited for the period beginning July 2011. Continued emphasis and updated guidance regarding prevention, identification and management of perinatal depression will be incorporated.

E. Health Status Indicators

Introduction

The MCH Program's ability to maintain or improve HSIs, interpretation of new data and strategies for the impacting upon the HSIs is described in detail in Section 3 of the Needs Assessment. A major focus for NYSDOH is on health disparities and the achievement of health equity. Numerous indicators are broken down by race and ethnicity in an effort to determine if certain groups are not benefiting equally from current interventions. Please refer to forms 20 and 21 for annual reporting of Health Status Indicators.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.3	8.3	8.1	8.2	8.2
Numerator	20367	20760	20560	20471	20471
Denominator	245378	249207	252662	249655	249655
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Narrative:
The percent of low birth weight has decreased slightly from 2006 for the entire NYS population (8.3) and also decreased in the Non-Medicaid population (8.2) but the rate has remained consistent at 8.6 for the Medicaid population. A focus of the DOH's efforts to reduce low birth weight is a systems-wide effort to improve early entry into comprehensive prenatal care and support and services offered through the Department's perinatal and home visiting programs as discussed in HSCI 04.
New York State has a well-organized system of regionalized perinatal care that ensures that appropriate hospital care is provided to women and their newborns. A system of regionalized perinatal services includes a hierarchy of three levels of perinatal care provided by the hospitals within a region and led by a regional perinatal center (RPC). Women at highest risk for poor birth outcomes are referred to RPCs and supportive health and social services. Research strongly supports regionalization as a means of improving maternal and infant outcomes.
The expansion of Medicaid prenatal care and the requirement that all Article 28 hospitals/ diagnostic and treatment centers that offer prenatal care provide Presumptive Eligibility to pregnant women expand access to prenatal care and Medicaid coverage. New York also passed legislation in 2009 allowing nurse practitioners to bill MA in all specialties, and licensed clinical social workers will be reimbursed for services to children, adolescents and pregnant women, thereby expanding access to health and supportive services.
The health of the woman prior to pregnancy significantly impacts birth outcomes. A preconception care packet, including Preconception Care checklist and Preconception Care Guide for Optimizing Pregnancy Outcomes, was developed in collaboration with the ACOG-NY, and distributed to over 16,000 obstetricians/gynecologists, nurse practitioners, and pediatricians. The materials are designed to encourage medical professionals to ask women about reproductive intentions at every visit, assess risk of an unplanned pregnancy, and counsel women on appropriate health behaviors to optimize pregnancy outcomes. The Department also funded development of the Preconception Health Café, a web-based course to about the importance of preconception health and provide tips to maximize opportunities to discuss preconception health with women.
Title V staff participate in interagency projects to address specific perinatal issues. A Fetal Alcohol Spectrum Disorder (FASD) Interagency Workgroup promotes coordination among State agencies to design and support a comprehensive system of care to eliminate alcohol use during pregnancy and improve the lives of New Yorkers affected by prenatal alcohol exposure. Representatives include: Council on Children and Families, Office of Children and Family Services, Office of Mental Retardation/ Developmental Disabilities, Office of Alcoholism and

Substance Abuse Services, and the DOH

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.4	6.4	6.2	6.3	6.3
Numerator	15020	15253	14994	15081	15081
Denominator	236138	239709	242655	240075	240075
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Narrative:
The singleton LBW rate of 6.3 percent in 2008 and 2009 represents a decrease from 2005 and 2006, but is still higher than the rather steady rate of 5.9 -- 6.1 percent from 1998 -- 2003. Issues such as access to comprehensive prenatal care, substance use and other issues can impact birth outcomes. As stated in the Needs Assessment section, within the Title V Program, and in collaboration with a wide range of internal and external partners, the Department administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services. New York State's has also been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the Department as a Level I, II, II or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.5	1.5	1.5	1.5	1.5
Numerator	3765	3849	3716	3733	3733
Denominator	245378	249207	252662	249655	249655
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Notes - 2008
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Narrative:
The VLBW rate of 1.5 percent in 2008 -2009 has shown little variation over the past decade. As stated in Health Status Indicator 1B, the Title V Programs has made significant efforts to improve birth outcomes through the development, implementation and oversight of a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes. Efforts made to ensure that all VLWB babies are born at facilities with services commensurate with their more complex needs have resulted in the vast majority of these babies being born at Level III hospitals and Regional Perinatal Centers. An analysis of mortality rates among VLBW babies has been conducted, and the results are in the process of being finalized. Preliminary findings indicate a substantial decrease in mortality rates for babies in the birthweight group since implementation of New York's perinatal regionalization initiatives.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.2	1.1	1.1	1.1
Numerator	2751	2767	2720	2706	2706
Denominator	236138	239709	242655	240075	240075
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Narrative:
The percent of singleton very low birthweight births (<1500 grams) in NYS has decreased slightly since 2006, but remained relatively consistent since that time. The percentage of very low birth weight infants delivered at facilities for high-risk deliveries has increased significantly from 84.6 % in 2002 to 90 % in 2008, which is most likely the result of the State's strong regionalized approach to birthing hospitals as described below. White -- Black disparities remains an issue for LBW as well as VLBW. As stated in the Needs Assessment and other sections of this application, the Title V Program, and in collaboration with a wide range of internal and external partners, the Department administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are part of an integrated effort to reduce health

disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services. New York State's has also been a national leader in the development of a statewide system of perinatal regionalization to better ensure that high risk mother s and babies receive the most appropriate level of care to improve perinatal outcomes.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.7	4.0	4.7	4.3	4.3
Numerator	138	148	168	155	155
Denominator	3744186	3698463	3597289	3604140	3604140
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

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Notes - 2007

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Narrative:

Approximately 2,677 children between the ages of 0-19 years are injured severely enough in a motor vehicle-related incident to require hospitalization annually. Another 1.5 million injured New Yorkers are seen in emergency departments every year. Approximately 27,788 children between 0-19 years are treated and released from an emergency department each year for a motor vehicle-related injury. The Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops programs to prevent them. It consists of unintentional injury prevention, violence prevention and injury surveillance programs. The Bureau is completing development of five tool kits and 48 fact sheets to provide up to date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly traffic related, for medical providers, researchers, educators and consumers. The toolkits include Shaken Baby Syndrome prevention, fire safety, falls prevention, child passenger safety, and bicycle safety. The toolkits will be available on the department website and in hard copy upon request.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.3	1.4	1.3	1.2	1.2
Numerator	49	50	48	43	43
Denominator	3744186	3698463	3597289	3604140	3604140
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Notes - 2007
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics

Narrative:
The death rate for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes has decreased slightly since 2007. As stated in National Performance Measure #10, the Department's Bureau of Injury Prevention has devoted significant effort in promoting efforts to decrease these injuries. The Bureau's Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the community is well informed on issues related to childhood injury prevention. Title V Programs such as the Community Health Worker Program, and prenatal care programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled in the Community Health Worker Program are also given extensive information about childhood safety. American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduction. Whenever possible, child safety messages are integrated into Department programs to maximize the impact of these messages.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	14.0	9.6	11.2	8.6	8.6
Numerator	366	360	313	240	240
Denominator	2620399	3754978	2790818	2802996	2802996
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Notes - 2007
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

Narrative:
The death rates for unintentional injuries due to motor vehicle crashed among youth aged 15 through 24 years has decreased significantly since 2005. As stated in the Needs Assessment section of this application, the Division of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops programs to prevent them. It consists of unintentional injury prevention, violence prevention and injury surveillance programs. The Childhood Injury Prevention Project thrived during the 2009-10 grant year with successful injury prevention coalitions established at the local level reaching out to diverse segments of the community to ensure the populace is well informed on issues related to childhood injury prevention. The Bureau of Injury prevention performed traffic related research and conducted surveillance of passenger, bicycle and pedestrian safety in NYS. New York has speared headed policies and programs such as New York's Graduated Driver's License program that has specific restrictions for drivers under 18 years of age and the school based education programs that promotes awareness and driver safety. The Bureau also represents the Department on the Governor's Traffic Safety Committee.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	268.9	260.4	270.3	253.0	253.0
Numerator	10069	9632	9722	9118	9118
Denominator	3744186	3698463	3597289	3604140	3604140
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Narrative:
The rate of nonfatal injuries among children aged 14 years and younger has declined significantly since 2005, but has been level since 2008. As stated in the Needs Assessment section of this application, the Division of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops

programs to prevent them. The Bureau of Injury Prevention has a long history of collaborating with groups, organizations and agencies to determine their needs and the needs of the public to decrease fatal and nonfatal injuries. In response to their requests the Bureau is completing development of five tool kits and 48 fact sheets to provide up to date data, best practices and evidence-informed programs to reduce unintentional injuries, particularly traffic related, for medical providers, researchers, educators and consumers. The toolkits include Shaken Baby Syndrome prevention, fire safety, falls prevention, child passenger safety, and bicycle safety. The toolkits will be available on the department website and in hard copy upon request.

Partnerships with other groups, agencies and organizations with a focus on childhood injury prevention continue to thrive promoting a coordinated message. A supplemental grant award from the CDC is supporting the development of a child injury prevention policy initiative. A symposium was held in winter 2010 for practitioners describing the problem of child injuries and introduce the toolkits. A second symposium is planned for spring 2010 to educate practitioners and provide the tools necessary to develop strategies for childhood policy promotion on the state and local level.

In December 2008, the WHO/UNICEF and the CDC issued reports about the problem of childhood unintentional injuries in the world and the US. In response to the reports, the Bureau of Injury Prevention developed the Child Injury Prevention Project to assist LHDs, hospitals, providers, caregivers and parents in preventing unintentional childhood injuries. These injuries are preventable and the Bureau is sharing the evidence-based strategies with the public, LHDs and hospital staff to reduce the risk of injury and disability. Key strengths of the program include strong partnerships with community and state level organizations with a focus on children and their families, such as OCFS, NYS Safe Kids Coalition, and the Governor's Traffic Safety Committee.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.9	30.1	29.0	25.8	25.8
Numerator	1020	1114	1044	929	929
Denominator	3790880	3698463	3597289	3604140	3604140
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.
Non-fatal MV related injuries include pedestrians and cyclists

Notes - 2008
Non-fatal MV related injuries include pedestrians and cyclists

Notes - 2007
Non-fatal MV related injuries include pedestrians and cyclists.

Narrative:
The rate for nonfatal injuries among children aged 14 years and younger due to motor vehicle crashes has decreased steadily 2006. The Department's Bureau of Injury Prevention has devoted significant effort in promoting efforts to decrease these injuries. The Bureau's Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the community is well informed on issues related to childhood injury prevention. Title V Programs such as the Community Health Worker Program, and prenatal care programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled in the Community Health Worker Program are also given extensive information about childhood safety. American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduction. Whenever possible, child safety messages are integrated into Department programs to maximize the impact of these messages.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	118.2	121.8	122.1	103.4	103.4
Numerator	3097	3355	3407	2898	2898
Denominator	2620399	2754978	2790818	2802996	2802996
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.
Non-fatal MV related injuries include pedestrians and cyclists

Notes - 2008
Non-fatal MV related injuries include pedestrians and cyclists

Notes - 2007
Non-fatal MV related injuries include pedestrians and cyclists

Narrative:
The rate for nonfatal injuries due to motor vehicle crashed among youth aged 15 through 24 years has decreased significantly since 2006. As stated in the Needs Assessment section of this application, the Division of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention identifies and monitors where and why injuries occur across the state and develops programs to prevent them. It consists of unintentional injury prevention, violence prevention and

injury surveillance programs. The Childhood Injury Prevention Project thrived during the 2009-10 grant year with successful injury prevention coalitions established at the local level reaching out to diverse segments of the community to ensure the populace is well informed on issues related to childhood injury prevention. The Bureau of Injury prevention performed traffic related research and conducted surveillance of passenger, bicycle and pedestrian safety in NYS. New York has speared headed policies and programs such as New York's Graduated Driver's License program that has specific restrictions for drivers under 18 years of age and the school based education programs that promote awareness and driver safety. The Bureau also represents the Department on the Governor's Traffic Safety Committee. In the coming year, the Department is also planning a one-day traffic safety symposium will be held to educate stakeholders, including adolescents, young adults and community members, about the risk of sustaining a traumatic brain injury from a motor-vehicle related incident. Relevant data and evidence-informed strategies and best practices will be shared with the participants.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	25.6	25.6	29.8	33.7	33.7
Numerator	16449	17351	20378	23104	23104
Denominator	643315	677708	683829	686495	686495
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Narrative:
The rate of Chlamydia increased significantly between 2005 and 2008, and remained level in 2009. As stated in the Needs Assessment section of this application, Chlamydia morbidity has continued to increase since reporting began in 2000. Women are disproportionately affected by Chlamydia. The case rate per 100,000 population for females in 2008 was more than twice the rate for males (623.3 vs. 296.6). Young women had the highest rates of infection. Among females 15-19 in New York State, the infection rate was 3,749.6 per 100,000, and among females aged 20-24, the rate was 3290.3 per 100,000. New York has a rich system of providing reproductive health services to our most vulnerable population. The NYS Family Planning Program in the Division of Family Health, Bureau of Maternal and Child Health provides comprehensive reproductive health care, including contraceptive education, counseling and methods as well as counseling and testing for HIV and sexually transmitted diseases to help contain major threats to public health, to assist low income, uninsured and underinsured women, racial and ethnic minorities, adolescents and men in determining their reproductive futures and in avoiding STIs and unintended pregnancy. The Family Planning Program served more than 340,000 women and men in 2008, including 58% minority and 89% under 150% of the Federal Poverty Level.

The Title V Programs also supports an array of adolescent health programs, as previously discussed, including the Community Based Adolescent Pregnancy Prevention (CBAPP)

programs that provide pregnancy prevention services in targeted high risk zip codes and employ a comprehensive model that includes: sexual health education to delay onset of sexual activity and reduce risky sexual behavior; educational, recreational and vocational opportunities as alternatives to sexual activity; and access to family planning services. The Title V programs has also recently initiated the Adolescent Sexual Health "Take Control" Media Campaign that is a cross-program media campaign aimed at promoting adolescent sexual health was successfully launched.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	11.4	10.0	10.6	10.6
Numerator	27515	38939	34020	35910	35910
Denominator	3441631	3418040	3395372	3389687	3389687
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 data are being used as a proxy for 2009.

Narrative:
The rate of Chlamydia increased significantly in 2006, and has remained relatively consistent since that time. As stated previously, New York has a rich system of providing reproductive health services to our most vulnerable population. The NYS Family Planning Program in the Division of Family Health, Bureau of Maternal and Child Health provides comprehensive reproductive health care, including contraceptive education, counseling and methods as well as counseling and testing for HIV and sexually transmitted diseases to help contain major threats to public health, to assist low income, uninsured and underinsured women, racial and ethnic minorities, adolescents and men in determining their reproductive futures and in avoiding STIs and unintended pregnancy. The Family Planning Program served more than 340,000 women and men in 2008, including 58% minority and 89% under 150% of the Federal Poverty Level. All providers conduct significant outreach to engage high risk individuals into the service system for the provision of comprehensive reproductive health care services.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**

Infants 0 to 1	250282	168695	59565	2420	19602	0	0	0
Children 1 through 4	958213	660926	211334	6746	79207	0	0	0
Children 5 through 9	1173057	835111	242042	7960	87944	0	0	0
Children 10 through 14	1222588	870353	258458	10395	83382	0	0	0
Children 15 through 19	1403050	1004909	298688	11570	87883	0	0	0
Children 20 through 24	1399946	1006545	284495	11924	96982	0	0	0
Children 0 through 24	6407136	4546539	1354582	51015	455000	0	0	0

Notes - 2011

Narrative:
As stated in the Needs Assessment section of this application, these data demonstrates the diversity that is New York. According to the 2008 American Community Survey, New York State is home to more than 19 million people (19,490,297). New York is now the third most populous state, behind California and Texas. Six percent of the US population lives in New York. New York City contains 43% of the State's population, with over 8 million people (8,363,710). New York's population reflects diverse race and ethnicity as it is more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. According to the American Community Survey conducted by the US Census Bureau, New York ranks second of all states in foreign born, with 21.7% of its total population or 4,236,768 people being foreign born in 2008. Almost 90% of New York's non-citizen immigrants live in New York City, with Queens County being the most diverse county in America. (As of the 2008 American Community Survey, immigrants comprise 47.4% of its residents.)

This diversity necessitates the focus on ensuring that programs and activities developed and implemented by the Department are targeted to the maternal and child health population served and are not only available, but are accessible by being ethnically and culturally sensitive. Initiatives such as the Prevention Agenda emphasize at the local and state level, the importance to developing service systems that will improve health outcomes for all and decrease health disparities.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	185820	64462	0
Children 1 through 4	725958	232255	0
Children 5 through 9	921842	251215	0
Children 10 through 14	983657	238931	0
Children 15 through 19	1143154	259896	0
Children 20 through 24	1138063	261883	0
Children 0 through 24	5098494	1308642	0

Notes - 2011

Narrative:
These data elucidate the diversity of New York's children. As stated in the Needs Assessment section of this application, between 1990 and 1998, there had been small shifts in the ethnic composition of New York's population, with the population of New York City being more racially and ethnically diverse than the rest of the State. The 1999 New York State population under age 24 was 72% white, 22% African American, and 18% Latino. Approximately 6% were identified as Asian/Pacific Islander.
In 2000, the Census, in an effort to reflect the growing diversity in the US, gave respondents the option of selecting one or more race categories to indicate their racial identities. Because of this change, data from the 2000 Census cannot be compared to earlier censuses. The six single race categories (White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, and Some Other Race) and the two or More Races category are exclusive categories. The majority of New Yorkers (96.9%) reported only one race; 3.1% identified themselves as being of more than one race.
The 2008 American Community Survey uses the same race categories as the 2000 Census. According to the 2008 American Community Survey, the largest group (67.2%) reported White alone, while Black or African American alone represented 15.9 percent of New Yorkers. 7.5% reported being Some Other Race. 7.0% stated they were Asian alone, and 0.4% reported they were American Indian or Alaska Native. Native Hawaiian or Other Pacific Islander accounted for only 0.03% of those reporting.
Hispanics accounted for the majority of the Some Other Race category. Of New York State residents who selected Some Other Race, 93.4 percent identified themselves as Hispanic. Hispanics represent 16.7% of New York State's total population. In New York City, 28% indicated they were Hispanic. Four out of 10 Hispanics did not identify themselves with one of the five specific race alone categories or two or more races category. Of those New Yorkers identifying themselves as Hispanic, 44.2 said they were Some Other Race.
Between 2000 and 2008, the Hispanic population increased from 13.9% to 16.7% of New York's total population. The percentage of Black or African Americans remained at 15.9% and the percentage of Asians increased from 5.5% to 6.9%.

As stated numerous times in this application, by expanding access to the public health insurance programs and developing and implementing health and supportive services in highest need areas of the state, New York is committed to providing quality services to the children, youth and adolescents of New York that are culturally and ethnically sensitive to the needs of the diverse population to ultimately address health disparities and improve health outcomes.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	242	115	102	0	2	0	0	23
Women 15 through 17	5074	2754	1720	15	65	0	0	520
Women 18 through 19	12171	7280	3539	33	245	0	0	1074

Women 20 through 34	182632	120162	32783	1703	16184	0	0	11800
Women 35 or older	49499	34536	7415	331	4708	0	0	2509
Women of all ages	249618	164847	45559	2082	21204	0	0	15926

Notes - 2011

Narrative:
As stated in the Needs Assessment section of this application, there were 249,655 births in New York State in 2008. In 2008, births to white mothers accounted for 66 percent of all births and births to Black mothers represented 18 percent of the total. Fifteen percent of births were in the "other" category. Births to Hispanic mothers accounted for almost 24 percent of all births. This includes births to persons of multiple races, as well as all other races. The majority of births occurred to women between the ages of 20 and 39 (89%). Women aged 45 plus had 819 births and women under fifteen had 242. Out-of-wedlock births accounted for 41.2 percent of total births. This is slightly more than in 2007 when 40.5 percent of births were out-of-wedlock. Mothers 17 years of age and younger were more likely (95%) to be unmarried compared to mothers aged 25 or older (30%). Out-of-wedlock births were also more common among Black (70.6%) and Hispanic (65.5%) mothers. Disparities between Black, white and Hispanic births have persisted over the past ten years.

The diversity of age as well as race present significant challenges to New York State. Addressing adolescent pregnancy is a priority of the Department and the Title V program. Adolescents are less likely to seek early prenatal care, therefore risking poor birth outcomes, and are also more likely to live in poverty. New York's adolescent health initiatives and comprehensive family planning program as discussed, in this application, strive to address this issue. New York State's perinatal programs employ a comprehensive, multi-level strategy, which integrates broad based systems approaches, involving county and local planning efforts, with one-on-one outreach through home visiting programs to assess, intervene and address the perinatal health needs of residents in high risk communities.

To address health disparities in birth outcomes, within the Title V Program, and in collaboration with a wide range of internal and external partners, the Department administers a number of programs and initiatives that collectively aim to provide a comprehensive, integrated set of services to support optimal perinatal outcomes for both mothers and babies. These programs are part of an integrated effort to reduce health disparities in affected communities by increasing access to and utilization of comprehensive and continuous early prenatal care and other services through early identification, enrollment and referral of pregnant women into prenatal care, home visiting and other needed services. NYS has also been a national leader in the development of a statewide system of perinatal regionalization. All obstetrical hospitals have been designated by the Department as a Level I, II, II or Regional Perinatal Center (RPC) based on standard criteria included in state regulation. Regulations require lower level hospitals to consult with RPCs and determine the need for transfer of high-risk mothers and newborns.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Total live births			

Women < 15	133	109	0
Women 15 through 17	2859	2215	0
Women 18 through 19	7511	4660	0
Women 20 through 34	138026	44606	0
Women 35 or older	41199	8300	0
Women of all ages	189728	59890	0

Notes - 2011

Narrative:
Refer to HIS 7A for information.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1359	723	492	3	52	8	0	81
Children 1 through 4	213	132	63	2	9	0	0	7
Children 5 through 9	136	90	36	0	6	0	0	4
Children 10 through 14	168	112	39	1	10	0	0	6
Children 15 through 19	495	301	155	2	21	1	0	15
Children 20 through 24	864	578	230	5	19	6	0	26
Children 0 through 24	3235	1936	1015	13	117	15	0	139

Notes - 2011

Narrative:
As stated in the Needs Assessment section of this application, Hispanic and White infant mortality rates have continued to be about half the rate for Black infants. Even though rates have been declining, Black infant mortality rates are still significantly higher than rates for both whites and Hispanics. New York's neonatal mortality rate mimics that of infant mortality. The postneonatal mortality rate in New York State has changed very little over the past decade. The disparities in rates between Blacks and Whites and Hispanics that were seen in both infant and neonatal mortality rates are also seen in postneonatal mortality.

Within the Title V Program, there are specific projects to monitor and analyze infant mortality data to guide the development of priorities and interventions. Based on 2005-2007 vital statistics data, the top five causes of infant death including conditions originating in the perinatal period (56.4%), congenital anomalies (18.7%), sudden infant death syndrome (4.1%), accidents (non-motor

vehicle injuries) (2.6%) and diseases of the heart (1.4%) accounted for 83% of all infant deaths. Based on an 11-year report on child deaths, communicable and chronic disease and unknown causes account for much of the remaining 17% of deaths. Driven by these data, in addition to enhanced prenatal activities, efforts to reduce infant mortality have focused on promotion of safe sleep and reduction of SIDS, including extensive risk reduction education for SIDS and other sleep related deaths, and work with local child fatality review and data collection activities to better understand the contributing factors to sleep related, other accidental deaths and homicides. In addition, the Title V program collaborates with other partner programs including WIC, Injury Prevention, Healthy Families New York (a home visiting programs administered by the state Office of Children and Family Services focused on the prevention of child abuse) and others to address factors that contribute to infant mortality.
The Title V program is also working with the state's Office of Children and Family Services (OCFS) to develop the Keeping NY Kids Alive program, that will expand and improve the quality of the child fatality review process. The initiative will assist in improving the skills of local officials who work in the child fatality review process to promote improved community services delivery and the development of local public health risk reduction and safety focused prevention programs.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1089	267	3
Children 1 through 4	172	41	0
Children 5 through 9	113	23	0
Children 10 through 14	134	34	0
Children 15 through 19	420	75	0
Children 20 through 24	703	161	0
Children 0 through 24	2631	601	3

Notes - 2011

Narrative:
Refer to HSI 8A for information.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	18090352	13436736	3192580	120374	1340661	0	0	0	2008
Percent in	35.0	0.0	0.0	0.0	0.0	0.0	0.0	35.0	2008

household headed by single parent									
Percent in TANF (Grant) families	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.9	2008
Number enrolled in Medicaid	2068245	0	0	0	0	0	0	2068245	2008
Number enrolled in SCHIP	394716	0	0	0	0	0	0	394716	2009
Number living in foster home care	25925	0	0	0	0	0	0	25925	2008
Number enrolled in food stamp program	851116	0	0	0	0	0	0	851116	2008
Number enrolled in WIC	492364	138270	116172	4295	38463	0	8433	186731	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2741.7	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9	2008

Notes - 2011
Source: NCHS population estimates - "Bridged Race Vintage 2008"

Source: US Census Bureau, 2008 American Community Survey

Source: US HHS, Office of Family Assistance, 2008 CY TANF Report. as pf 11/18/09. 193,654 children in TANF family.

Source: NYS Department of Health, Office of Medicaid Management, FFY 2008 CMS416 Report.

Source: NYS Office of Temporary and Disability Assistance, Welfare Management System

Source: NYS Pediatric Nutrition Surveillance System, 2008

Data includes 44,722 arrests for violent and property index crimes in NYS among youth ages 16021. The rate is based on a population figure of 1,631,205 youth ages 16-21.
Source: NYS Division of Criminal Justice Services, Computerized Criminal History System.

Drop-out rates are for public school students for the 2008-2009 school year.

Source: NYS Office of children and Family Services, Child Care Review Service.

Narrative:

New York's commitment to its citizens, including children 0 through 19 years of age, is demonstrated by the significant supports and services available to New York's most vulnerable population. Through their various health and human service programs offered by the Department, as well as sister agencies, such as health care services funded by public insurance programs, family planning and reproductive health care, and the array of adolescent health initiatives, including youth development activities, New York strives to support its youth to decrease health disparities, reach the high risk populations, such as those children living in poverty and foster care, and foster self sufficiency and youth development in order that all youth become healthy, productive citizens.

In order to ensure coordination and collaboration to improve outcomes for all New York's children, the Governor's Children's Cabinet established an Early Childhood Advisory Council, in which the Department participates. The Council is assessing cross-systems priorities and strategies for streamlining services for families with young children, including health, mental health, early care and education, parenting education, support and other systems.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	15102196	2988155	0	2008
Percent in household headed by single parent	0.0	0.0	35.0	2008
Percent in TANF (Grant) families	0.0	0.0	3.9	2008
Number enrolled in Medicaid	0	0	2068245	2008
Number enrolled in SCHIP	0	0	394716	2009
Number living in foster home care	0	0	25925	2008
Number enrolled in food stamp program	0	0	851116	2008
Number enrolled in WIC	305633	186731	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2741.7	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	2.9	2008

Notes - 2011
Source: NCHS population estimates - "Bridged Race Vintage 2008"

Narrative:
As stated in the Needs Assessment section of this application, New York's population reflects diverse race and ethnicity as it is more diverse than the nation as a whole. New York has higher percentages of non-Hispanic Black residents, Hispanic residents and non-citizen immigrant residents than the U.S. average. New York's commitment to its citizens, including children 0 through 19 years of age, is demonstrated by the significant supports and services available to New York's most vulnerable population. Through their various health and human service programs offered by the Department, as well as sister agencies, such as health care services funded by public insurance programs, family planning and reproductive health care, and the array of adolescent health initiatives, including youth development activities, New York strives to

support its youth to decrease health disparities, reach the high risk populations, such as those children living in poverty and foster care, and foster self sufficiency and youth development in order that all youth become healthy, productive citizens.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	4479000
Living in urban areas	4479000
Living in rural areas	390000
Living in frontier areas	0
Total - all children 0 through 19	4869000

Notes - 2011
Population living in Rural (8%) and Urban (92%) areas based on 2009 State Fact Sheet, USDA, Economic Research Service. Child population, 2008 population estimates.

Population living in Rural (8%) and Urban (92%) areas based on 2009 State Fact Sheet, USDA, Economic Research Service. Child population, 2008 population estimates

Narrative:
These data show that a large majority of New York's children aged 0 through 19 years resides in urban and metropolitan areas of the state, with a much smaller number in rural New York State. Population density often determines the number and types of health services that an area can support. The US Census shows that in 2000 there were 401.9 persons per square mile in New York State, compared to 79.6 persons per square mile in the US. New Yorkers are more likely to live in urban areas than residents of other states. As stated in the Needs Assessment section of this application, population density within New York varies widely. New York City is 104 times more densely populated than the rest of the state. New York City comprises over 40% of New York State's population, and the counties immediately north of New York City (Orange and Westchester Counties) and Long Island (Nassau and Suffolk Counties) comprise an additional 21% of the state's population. Other population centers are Buffalo (Erie County), Rochester (Monroe County), Syracuse (Onondaga County) and Albany (Albany County).
Many areas of New York are also rural. Twenty-six percent of New Yorkers live in rural areas, compared to 36% nationwide.

This presents a significant challenge in ensuring quality services are available in diverse areas of the state, while maximizing limited resources. The Department often uses Vital Records data to identify areas where significant needs and health disparities exist. Areas are rank ordered on multiple indicators through zip code level analyses of rates of adverse outcomes to ensure provision of services to residents living in the highest risk communities, with the intent of reducing health disparities and improving outcomes. Vital Records and program data are routinely assessed to determine the impact on stated goals and to identify areas for quality improvements efforts. For example, adolescent health initiatives are targeted to the highest areas of risk including teen pregnancy rate, STIS, among others.

Department funded providers are also required to identify areas of need within high risk areas, identify gaps, barriers and challenges, and address those issues for their programs services. These issues may include proximity of services to the population served, and marketing those services to the high risk population.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	19309000.0
Percent Below: 50% of poverty	6.1
100% of poverty	14.2
200% of poverty	31.4

Notes - 2011
Source: 2009 Current Population Survey, 2008 data.

Source: 2009 Current Population Survey, 2008 data

Source: 2009 Current Population Survey, 2008 data

Source: 2009 Current Population Survey, 2008 data

Narrative:
These data highlight New York's challenge of addressing supports and services for those individuals at or below 200% of fpl. Approximately 50% of New Yorkers are at 200% of the fpl and below. 20% of these individuals are at 100% of fpl or below. Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. New York is committed to ensuring programs and services are available to provide health care and support for New York's most vulnerable children and families. In 2008, New York took a bold step towards ensuring universal coverage for children in the State when, prior to federal funding support, it increased the income eligibility threshold for Child Health Plus from 250 to 400 percent of the federal poverty level, making an additional 70,000 children eligible for subsidized health insurance coverage. In addition, the State expanded Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160% of the federal poverty level. Medicaid coverage for foster care children was also extended through age 20 to address the long standing problems children in foster care have had in transitioning to adulthood and independence. The state has also made substantial process in streamlining the Medicaid eligibility process.
Birth spacing and timing of births are significant in improving birth outcomes and allowing adolescents and women determine their reproductive future. Delaying pregnancy may help women in poverty further their education and become more gainfully employed. Comprehensive family planning and reproductive health care services are available at 49 family planning agencies providing services in 189 sites, including four mobile units providing services statewide. Title V program has worked diligently with the Medicaid program to increase access to reproductive health services for Medicaid eligible women. In 1996, the Medicaid managed care legislation expanded Medicaid benefits for 26 month after the end of a pregnancy to women under 185 percent of the federal poverty level who had previously been on Medicaid while pregnant and subsequently lost coverage. In addition, in 2006, the MCH program and OHIP collaborated in developing and implementing the state's waiver to expand family planning services for individuals up to 200 percent of the federal poverty level. Medicaid prenatal care services and the array of home visiting services offered in New York (as discussed previously) provide supports and services to better ensure improved birth outcomes and provide support to

mothers, children and families.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	4869000.0
Percent Below: 50% of poverty	9.1
100% of poverty	19.9
200% of poverty	40.2

Notes - 2011
Source: 2009 Current Population Survey, 2008 data

Source: 2009 Current Population Survey, 2008 data

Source: 2009 Current Population Survey, 2008 data

Source: 2009 Current Population Survey, 2008 data

Narrative:
Poverty is highly associated with poor health outcomes, especially for women and children. Poverty is most common in families headed by single females, and single-female headed households with children are more likely than other families to be living below poverty. This is true regardless of race or ethnicity. Given this, New York continues its commitment to reduce rates of teen pregnancy and out-of-wedlock births and to provide poor heads of households with jobs. According to the 2009 Current Population Survey, during 2008, 38.9 percent of the people in female-headed households with children lived below poverty in New York State. In 2008, 881,000 of New York's children (21.3 percent) were living below poverty. This is slightly higher than the 19 percent in the nation as a whole.

New York is committed to ensuring programs and services are available to provide health care and support for New York's most vulnerable children and families. In 2008, New York took a bold step towards ensuring universal coverage for children in the State when, prior to federal funding support, it increased the income eligibility threshold for Child Health Plus from 250 to 400 percent of the federal poverty level, making an additional 70,000 children eligible for subsidized health insurance coverage. In addition, the State expanded Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160 % of the federal poverty level. Medicaid coverage for foster care children was also extended through age 20 to address the long standing problems children in foster care have had in transitioning to adulthood and independence. The state has also made substantial process in streamlining the Medicaid eligibility process.
New York has the largest School Based Health Center program in the country to serve as a safety net for the provision of primary and preventive health care in high need neighborhoods schools in the state. Medicaid prenatal care services and the array of home visiting services offered in New York (as discussed previously) provide supports and services to better ensure improved birth outcomes and provide support to mothers, children and families.

F. Other Program Activities

With the exception of injuries to young children, all MCH activities fall within priorities for the MCHBG 2011-2016 grant cycle. Injury prevention for young children continues to be a priority for the Department, however it could not be subsumed readily under the new priorities. Department efforts to address injury prevention in children and adolescents are described in Section 3 of the needs assessment.

The Bureau of Maternal and Child Health supervises the operation of the toll-free Growing Up Healthy Hotline (1-800-522-5006 and TTY 800-655-1789). The hotline provides information to pregnant women, mothers, children and adolescents on over thirty topics, and helps to ensure access to needed maternal and child health services. It operates 24 hours per day/seven days per week, with both English- and Spanish-speaking trained tele-counselors. Answering services are contracted to the Association for the Blind and Visually Impaired, Goodwill Inc., a not-for-profit telecommunications group that specializes in community information and referral services. A requirement of the contract is that callers will be immediately connected to an information specialist, with no busy signal or answering tape, at least 94% of the time. The contractor actually achieves 98%, which is one of the best performances in the nation. In order to maximize its usefulness, the Growing Up Healthy Hotline provides services for the hearing-impaired and to people who are not English- or Spanish-speaking through the AT&T Language Line, extending access to referral services to callers speaking over twenty additional languages.

In 2009 the Growing Up Healthy Hotline provided information to 61,518 callers on a variety of maternal and child health issues, including information on eligibility for programs and the location of the nearest services. Of these, 7,918 were for provision of pregnancy-related information and services. Less than five percent (3,062) of calls required handling in languages other than English. Of these calls, 2,958 were from Spanish-speaking callers and 104 of the calls were in languages other than English or Spanish. Seventy-nine percent of callers were female, and 21% male. There was an 11% decrease in the total number of calls to the hotline in 2009 compared to 2008 and a 1.7% increase compared to 2007.

Last year, callers requested assistance in the following areas: adult insurance 0.6%, Child Health Plus 2.8%, child/adult care food program 1.6%, dental/orthodontia 0.9%, early intervention 1.7%, educational materials 0.3%, Family Health Plus .9%, family planning 2%, farmer's market 4.8%, food and nutrition programs 1.6%, health department programs 0.9%, immunizations 0.2%, Medicaid for adults 2.9%, Medicaid for children 1%, newborn screening 0.5%, pregnancy testing 0.1%, pregnancy care 12.8%, rape crisis 0.3%, social services 1.7%, summer food program 2.9%, WIC 54.8%, WIC complaints 1.3%, and other 3.2%. Twelve callers asked about perinatal depression information and services.

The hotline number is published in local telephone directories and used in public information campaigns directed at the maternal and child health population throughout the state. The most frequent sources of reference to the hotline are community organizations, the internet, WIC, doctor's offices, friends or relatives, pamphlets, insurance company materials, hospitals, letters, telephone book, bus/train/subway placard, and farmer's markets.

When appropriate, callers are also given toll-free hotline numbers where they may have questions answered about AIDS, child abuse, domestic violence, substance abuse, and assistance for people with disabilities.

Title V staff test the availability and accuracy of the hotline at various times, with positive results.

G. Technical Assistance

Programs have not identified any technical assistance needs for this cycle. We do, however, reserve the option to request technical assistance as necessary during the year.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	41629217	41036806	41043769		41036806	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	390311698	360267459	363695631		336529505	
4. Local MCH Funds *(Line4, Form 2)*	309987228	315619141	299499317		313430367	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	174723376	187342102	176715455		173450785	
7. Subtotal	916651519	904265508	880954172		864447463	
8. Other Federal Funds *(Line10, Form 2)*	46143937	43118307	45901844		75196798	
9. Total *(Line11, Form 2)*	962795456	947383815	926856016		939644261	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	76287545	70922081	77507975		70606837	
b. Infants < 1 year old	46193308	44833643	67645380		38939501	

c. Children 1 to 22 years old	125026052	108881991	121371304		109314803	
d. Children with Special Healthcare Needs	540975612	580974370	506821678		566769437	
e. Others	112109458	89425117	94488959		70749273	
f. Administration	16059544	9228306	13118876		8067612	
g. SUBTOTAL	916651519	904265508	880954172		864447463	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	150000		150000		0	
b. SSDI	100000		568638		93713	
c. CISS	140000		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	1939252		1334619		1724830	
j. Education	23636568		23831850		50238349	
k. Other						
HRSA	0		0		1131973	
Medicaid Match	9758117		9503861		8546452	
TANF	0		0		2500000	
Title X	0		0		10961481	
Title X-Fam Planning	10420000		10512876		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	542289899	567918281	549101044		581216529	
II. Enabling Services	72957273	69242156	73676681		59929280	
III. Population-Based Services	110605239	91433990	114544747		88451645	
IV. Infrastructure Building Services	190799108	175671081	143631700		134850009	
V. Federal-State Title V Block Grant Partnership Total	916651519	904265508	880954172		864447463	

A. Expenditures

Completion of Budget Forms: Please refer to budget columns on Forms 2, 3, 4, and 5 for a summary of state, local, federal and program income as it contributes to the MCH Partnership.

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Services Block Grant Funds in the block grant

Historical Note: Budgeted and expended amounts are shown on Form 3 within Line 1 only based on guidance provided by HRSA in FFY 2006. The total Federal allocation is committed to program services.

Program managers prepare a report on the population served by pyramid level. Expenditure reports are generated for the appropriate period and distributions by population and pyramid level are then calculated.

For FFY09, total partnership expenditures were 1.31% less than the budgeted allocation. A number of factors contributed to this reduction: the MCHSBG allocation was $592,411 less than the application budget amount; the implementation of new and enhanced initiatives was delayed; and, NYS's response to its budget deficit resulted in state funding reductions of numerous appropriations.

B. Budget

The FFY 2011 total partnership budget is $ 864,447,463. New York State's allocation of $336,529,505 demonstrates a continued obligation of funds above our statutory maintenance of effort level from FY1989 of $58,268,752. This level of state funding budgeted includes a State Match ($3 state for every $4 federal) of $30,777,603 for the $41,036,806 of Federal MCH Block Grant funds and an overmatch of $305,751,902.

This budget reflects New York State's commitment to Title V programs and services. New York more than meets the maintenance of effort requirements of Section 505 (a) (4) and match requirements for FFY 2011 which assures continuation of essential maternal and child health services.

Obvious variances in the FY 2011 amount from the FY 2010 amount can be attributed to increased levels of review and assessment of the populations being served and the type of service being provided by initiative; and, in light of the state's budget situation, ensuring that resources are being targeted for unmet needs. For example, the American Indian Health program, for which 50 percent of their state funding is attributable to maternal and child health, had previously been identified as "Population-based Services". Under NYS Public Health Law, the state provides for the ambulatory medical care of Native Americans living on reservations in NYS, as such, the majority of the services are "Direct Health Care". This discrepancy was identified and corrected. The Department has increased efforts to identify and match state dollars for appropriate initiatives; a result of this has been a decrease or elimination of those dollars in the MCHSBG application. Although these dollars are no longer included, the maternal and child health related services continue to be provided by the state at the same level. The re-evaluation of service delivery has resulted in a budget that more closely aligns with the FY2009 expenditures being reported.

The MCHSBG Advisory Council assists the Department in determining program priorities and is instrumental in seeking public input into the application process. The "Principles and Guidelines for the Use of Block Grant Funds", developed and revised as necessary by the Advisory Council, continues to be used. Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and

populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V. The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children ($13,634,547, 33.23%), for 30% for children with special health care needs ($12,467,244, 30.38%) and under 10% for administration ($2,274,958 or 5.54%) for block grant distribution.

New York State plans to use its Federal MCH funds for the following programs:
The Adolescent Health Initiative, including Centers for excellence and Youth Risk Behavior Surveillance; American Indian Health Program Community Health Workers;
Asthma Coalitions; Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program; Community-Based Adolescent Pregnancy Prevention; Family Planning; The Genetics Program and Newborn Metabolic Screening; SUNY School of Public Health MCH Graduate Assistantship Program; Health Communications; Infant and Child Mortality Review; Lead Poisoning Prevention; Migrant and Seasonal Farmworker Health; Statewide Dental Technical Assistance Center; Osteoporosis Prevention; Parent and Consumer Focus Groups; Public Health Information/Community Assessment infrastructure; Preventive Dentistry Initiatives; the Dental Residency Program; Dental Supplemental Fluoride Program, School-Based Health Centers; STD Screening and Education; and, Diabetes Prevention in Children.

The state share for MCH services is considerable, more than meeting the requirements for state match. New York State-funded programs dedicated to MCH include:

Early Intervention; Family Planning; Genetic Screening and Human Genetics;
Immunization, Vaccine Distribution and State Aid for Immunization; Lead Control and Prevention, Lead Poisoning Prevention and Lead Regional Resource Centers; Physically Handicapped Children's Treatment Program; Migrant and Seasonal Farmworker Health Program; Community Health Worker; Comprehensive Prenatal-Perinatal Services Networks, Perinatal Regionalization; Statewide regional perinatal systems; Infertility services; School-Based Health Centers; SIDS and Infant Death, Child's Asthma Program, Diabetes (Type II) Prevention in Children Program, HPV Vaccine, Growing Up Health Hotline, Healthy Mom, Healthy Babies Home Visitation Program, State HIV-related appropriations included in previous applications as match are no longer being included as those dollars are used as match for other federal grants. However, services continue to be a component of the NYS MCH related programming.

The methodology used to identify State expenditures for MCH-related programs has also not changed from prior years:

• Appropriate cost centers, representing specific areas of activity related to MCH, are identified.
• Data for the appropriate fiscal periods are obtained from the Office of the State Comptroller
• Data for selected cost centers are extracted on a quarterly basis.
• Data is compiled from relevant cost centers to reflect expenditures made during the federal grant award period.
• All expenditure data represent payments made on a cash (vs. accrual) basis.
• Transactions associated with specific grants are identified and tracked through appropriation, segregation, encumbrance and reporting processes to permit proper and complete recording of the utilization of available funds.
• Identifying codes are assigned to record these transactions by object of expense within each cost center.

The Department and the Office of the State Comptroller maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a) (1) for the purpose of maintaining an audit trail. Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

Federal sources of MCH targeted dollars other than the block grant included: Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health), Department of Education, IDEA Part C; Family Planning Title X; STD/fertility; SPRANS Grants; HRSA -- Ryan White HIV/AIDS Treatment Modernization Act of 2006; Oral Health; SSDI Funds; TANF Funds; Early Childhood Comprehensive Systems planning grant.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.